Client Health Evaluation and Intake Form

(Please complete all sections and bring along to your appointment)

Nutritional Health Therapies

CLIENT MEDICAL RECORD							
Date: / /				**CLIENT NO.** (Office Use ONLY)			
Last Name:				**Gender:**			
First Name:				**Ethnicity:**			
D.O.B.:		**Age:**		**Place of Birth:**			
Address:							
				Occupation:			
Suburb:		**Postcode**		**Weight:**		**Height:**	
State:		**Country**		**B.P.**		**H.R.**	
☎ **Home:**				**Blood type:**		**R.R.**	
☎ **Work:**				**Cigarettes**	/d	**Alcohol**	/d
☎ **Mobile:**				**Contact Lenses**	☐ Yes	☐ No	
Email:				**Sport/Hobbies:**			

Emergency Contact:			
Marital Status:	Single/Defacto/Married/Separated/Divorced/Widowed	**No. of Children:**	

Family Doctor:		**Referred By:**	
Contact No.:		**Contact No.:**	

Other Health Care Professionals Currently Seeing: [e.g. Chiropractor, Counsellor, Specialist, Natural Medicine Practitioner]
Reason for consultation today:

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Pre-existing conditions/Medical History: (Illness/operations/details/when?)	**Current Medication:**

Fractures or Accidents (if yes, when?)	**Implants:** (Please list - e.g. pacemaker / metal pins)

Family Medical History:	**Allergies:** (Please list)
Mother:	
Mum's Mother:	
Mum's Father:	
Dad:	
Dad's Mother:	
Dad's Father:	

Please indicate whether you have or have had any of the following conditions:

- ☐ High / Low BP
  Is it regulated? YES / NO
- ☐ Heart Problems
- ☐ Asthma/chest conditions
- ☐ Tuberculosis
- ☐ Thrombosis/circulatory condition
- ☐ Haemophilia/bruising
- ☐ Stroke
- ☐ Varicose veins
- ☐ HIV positive / Aids
- ☐ Migraines / Headaches
- ☐ Fainting/blackout
- ☐ Vertigo
- ☐ Sciatica/lumbago/back pain
- ☐ Claustrophobia
- ☐ Joint pain/ discomfort
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Problems with any organs
- ☐ Cancer
  What type? _____
- ☐ Reproductive problems
- ☐ Pregnant/ how many weeks
- ☐ Are you trying to get Pregnant?
- ☐ Fluid retention
- ☐ Skin conditions
- ☐ Stress
- ☐ Allergies
- ☐ Other_____

_____

Do you have any other diseases or conditions that you are aware of? **Yes** ☐ **No** ☐

If yes, please list:

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Please read the following and sign to indicate your understanding and declaration of consent:

- I affirm that I have stated all my known medical conditions, and answered all questions honestly
- I agree to keep the therapist updated as to any changes in my medical profile during the session/s and I understand that there shall be no liability on the therapist's part should I fail to do so.
- I understand that Nutritionists do not give medical diagnosis but do correct imbalances that are revealed during a consultation.
- I further appreciate that my doctor is medically responsible for me and my dependents and it is my responsibility to consult my doctor about any pain, problem or disease that I am presently aware of, or become aware of in the future.
- I hereby acknowledge the terms and conditions of the consultation and treatments as stated above and that information provided on this form is accurate, current and will be maintained in accordance with the My Health Records Act (2012), National Privacy Principles and the Privacy Act (2001).

Name: _____ Signature: _____ Date: ___ / ___ / ___

If patient under 18, signature of parent or guardian required (parent guardian must also attend clinic appointment)

Parent/ Guardian:_____ Signature:_____ Date: ___ / ___ /___

Thank you for your time with completing this form!