WELCOME TO MEDICUS

Last Name	D.O.B.	DATE	NUMBER
First Name Mr / Mrs / Miss / Ms / Master			

Address: .....

Suburb: ..... Post Code: .....

Home Phone: ..... Mobile Phone: .....

Email address: .....

Marital Status
☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed

Sport / Hobbies you regularly participate...
.....

Next of Kin: ..... Relationship.: .....

Name of person that
referred you to us: .....

Your occupation: .....

Previous occupations:: .....

Where were you born (Country)? .....

What language(s) do you speak? .....

☑ PLEASE INDICATE IF YOU HAVE A HISTORY OF THE FOLLOWING

☐ Acidity problems
☐ Acne
☐ AIDS, HIV
☐ Alcoholism
☐ Allergies
☐ Alopecia
☐ Alzheimer's
☐ Anaemia
☐ Angina
☐ Anxiety
☐ Appendicitis
☐ Arteriosclerosis
☐ Arthritis
☐ Asthma
☐ Bell's Palsy
☐ Bleeding disorders
☐ Blood clots, thrombosis
☐ Blood preassure
☐ Cancer
☐ Candida
☐ Cataract
☐ Coeliac disease
☐ Cellulite
☐ Cholera
☐ Cholesterol
☐ Chronic fatigue
☐ Circulation problems
☐ Cold Sores
☐ Colitis
☐ Constipation
☐ Convulsive disorders
☐ Cough
☐ Cramps
☐ Cysts
☐ Dandruff
☐ Dementia
☐ Depression
☐ Diabetes
☐ Digestion
☐ Diarrhea
☐ Diphtheria
☐ Eczema
☐ Emphysema
☐ Endometriosis
☐ Epilepsy
☐ Fainting
☐ Fatigue
☐ Fertility issues
☐ Fever issues
☐ Fibroids
☐ Fibromyalgia
☐ Gall Stones
☐ Gastritis
☐ Glandular fever
☐ Goitre
☐ Gout
☐ Haemorrhoids
☐ Hayfever
☐ Headache problems
☐ Heart problems
☐ Hepatitis
☐ High blood pressure
☐ Impotence
☐ Infection issues
☐ Influenza
☐ Insomnia
☐ Irritable bowel
☐ Kidney disease
☐ Kidney stones
☐ Libido issues
☐ Liver issues
☐ Low blood pressure
☐ Lumbago
☐ Lymph issues
☐ Malaria
☐ Measles
☐ Memory issues
☐ Meningitis
☐ Menstruation issues
☐ Migraines
☐ Miscarriage
☐ Multiple sclerosis
☐ Mumps
☐ Pain issues
☐ Panic attacks
☐ Parkinson's disease
☐ Phobias
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Polycystic ovaries
☐ Polyps
☐ Prostate issues
☐ Psoriasis
☐ Reflux
☐ Respiratory issues
☐ Rheumatic fever
☐ Rheumatism
☐ R.S.I.
☐ Scarlet fever
☐ Sciatica
☐ Sexual dysfunction
☐ Shingles
☐ Sinusitis
☐ Skin problems
☐ Sleep apnoea
☐ Snoring
☐ STD issues
☐ Stress
☐ Stroke
☐ Thalassemia
☐ Thyroid issues
☐ Tinnitus
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcers
☐ Varicose veins
☐ Venereal disease
☐ Vertigo
☐ Warts
☐ Weight disorders
☐ Whooping cough
☐ Worms
☐ .....
☐ .....
☐ .....

HOW CAN WE HELP YOU FEEL BETTER? PLEASE *PRINT* REASONS FOR YOUR VISIT TODAY

	YOUR FIRST (MAJOR) COMPLAINT	YOUR SECOND COMPLAINT	YOUR THIRD COMPLAINT
What is your complaint?			
How long have you had this condition?			
Have you had this condition or similar in the past?			
Is this condition getting worse?	☐ Yes ☐ Constant ☐ No ☐ Comes and Goes	☐ Yes ☐ Constant ☐ No ☐ Comes and Goes	☐ Yes ☐ Constant ☐ No ☐ Comes and Goes
Is this condition interfering with ….	☐ Work ☐ Daily Routine ☐ Sleep ☐ Other	☐ Work ☐ Daily Routine ☐ Sleep ☐ Other	☐ Work ☐ Daily Routine ☐ Sleep ☐ Other
<u>Previous</u> diagnoses and treatments you have received for this condition.			
<u>Current</u> diagnoses and treatments you are receiving for this condition.			

LIST MEDICATION & SUPPLEMENTS YOU HAVE BEEN TAKING

NAME	PURPOSE

LIST MEDICATION THAT YOU ARE ALLERGIC TO

LIST MEDICATION THAT YOU ARE ALLERGIC TO	LIST FOODS THAT YOU REACT TO

LIST THE FOODS YOU **<u>DO NOT WANT</u>** TO EAT

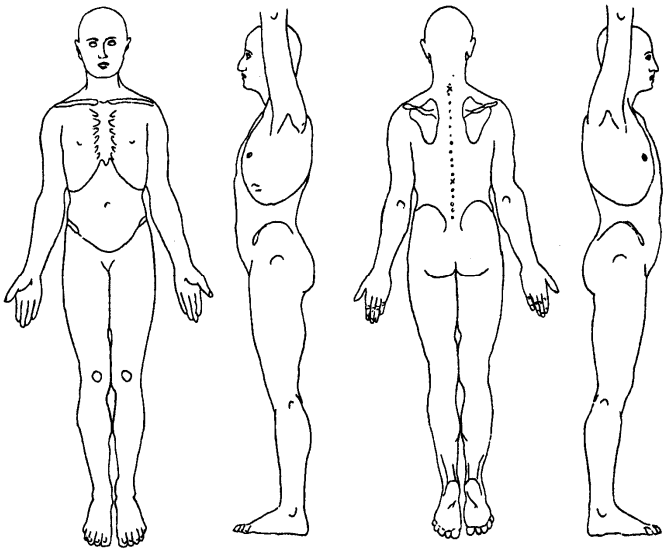
FOOD	REASON

WHAT OPERATIONS YOU HAVE HAD?

OPERATION	REASON / YEAR

WHERE ARE THEY ON YOUR BODY….

Do you have any tattoos? ☐ YES ☐ NO
Have you any body piercing? ☐ YES ☐ NO
Have you had any previous operations? ☐ YES ☐ NO
Do you have any injury scars? ☐ YES ☐ NO
Do you have any surgical implants? ☐ YES ☐ NO



TELL ME ABOUT THE HEALTH OF….

Your Mother
……

Your Father
……

Your Brother/Sister
……

Your Brother/Sister
……

Your Brother/Sister
……

Your Son/Daughter
……

Your Son/Daughter
……

Your Son/Daughter
……

Your Son/Daughter
……

Have there been unexplained fatalities?
……

LIFESTYLE & SELF-CARE

ALCOHOL CONSUMPTION
What quantity per week?

TOBACCO CONSUMPTION
How many do you smoke per week?

DENTAL
Your last visit to the dentist was on …..

VISION
Your last visit to your optometrist was…..

PAP or PSA
When was your last test?

WATER CONSUMPTION
How much water do you drink per day?

EXERCISE
Hours per week*?*

DEFECATION
Bowel movements per *week?* *Problems?* YES / NO

MICTURITION
Times per day you pass urine? *Problems?* YES / NO

YOUR HISTORY

Have you been to hospital as a patient?	☐ YES ☐ NO
Have you ever had a fractured bone?	☐ YES ☐ NO
Have you any surgical implants?	☐ YES ☐ NO
When standing from the sitting or lying position, is it difficult to straighten up?	☐ YES ☐ NO
Have you ever been concussed?	☐ YES ☐ NO
Do you ever get pins & needles?	☐ YES ☐ NO
Do any part(s) of your body get / become numb or tingle?	☐ YES ☐ NO
Have you ever had whiplash ?	☐ YES ☐ NO
Have you had any head injuries?	☐ YES ☐ NO
Have you ever suffered any type of facial trauma?	☐ YES ☐ NO
Have you ever had neck or spinal injuries?	☐ YES ☐ NO
Have you ever been in an accident?	☐ YES ☐ NO
Have you ever been in a car accident?	☐ YES ☐ NO
Have you ever been a passenger in an accident?	☐ YES ☐ NO
Have you ever needed to use a neck or back brace?	☐ YES ☐ NO
Have you ever needed to use a walking stick / frame?	☐ YES ☐ NO
Have you ever been taken to hospital in an ambulance?	☐ YES ☐ NO
Have you had any long term type of pain?	☐ YES ☐ NO
Have you had any long term type of swelling?	☐ YES ☐ NO
Have you ever suffered any serious illness?	☐ YES ☐ NO
Are you at present receiving medical attention for that illness?	☐ YES ☐ NO
Are you at present taking medicines or tablets for ANY reason?	☐ YES ☐ NO
Have you ever had any panic attacks and/or depression?	☐ YES ☐ NO
Have you ever experienced sudden disorientation, mood swings, strong cravings and / or dizzy spells?	☐ YES ☐ NO
Have you ever had any mental or emotional disorders?	☐ YES ☐ NO
Have others in your family had any mental or emotional disorders?	☐ YES ☐ NO
Are you in the high risk group for AIDS, HIV or Hepatitis B?	☐ YES ☐ NO
Have you ever been knocked unconscious?	☐ YES ☐ NO
Are you subject to prolonged bleeding or frequent nose bleeds?	☐ YES ☐ NO
Have you ever been given cortisone or steroid tablets or injections?	☐ YES ☐ NO
How long has it been since you really felt good?	
Is there anything of a confidential nature you wish to discuss with the doctor / nurse?	☐ YES ☐ NO

HAVE YOU EVER….

Had ***Biopsy?*** If yes, please bring the report on your next visit.	☐ YES ☐ NO
Had ***Chemotherapy?*** If yes, please bring the report on your next visit.	☐ YES ☐ NO
Had ***Radiation Therapy?*** If yes, please bring the report on your next visit.	☐ YES ☐ NO
Had ***Shock Therapy?*** If yes, please bring the report on your next visit.	☐ YES ☐ NO

IN THE PAST 5 YEARS….

Have you ever had ***Blood Tests?*** If yes, please bring the report on your next visit.	☐ YES ☐ NO
Have you ever had ***CT Scans?*** If yes, please bring the report on your next visit.	☐ YES ☐ NO
Have you ever had ***MRI?*** If yes, please bring the report on your next visit.	☐ YES ☐ NO
Have you ever had ***Ultra Sounds?*** If yes, please bring the report on your next visit.	☐ YES ☐ NO
Have you ever had ***X-Rays?*** If yes, please bring the report on your next visit.	☐ YES ☐ NO
Do you ever feel as though you have a temperature? (Includes mild and non-specific one-off episodes)	☐ YES ☐ NO
If YES to the above question. How often would this happen?	

QUESTIONS FOR MEN

Have you noticed a weakening of the urine stream?	☐ YES ☐ NO
Have you noticed that the urine flow stops and starts while urinating?	☐ YES ☐ NO
Have you noticed a sensation that the bladder is not completely emptied after you've finished urinating?	☐ YES ☐ NO
Have you noticed that you have to push or strain to begin urination?	☐ YES ☐ NO
Have you noticed that you have to urinate again less than two hours after you finished urination?	☐ YES ☐ NO
Have you noticed that it is more difficult to postpone urination?	☐ YES ☐ NO
Have you noticed that you need to get up at night to urinate more often?	☐ YES ☐ NO

QUESTIONS FOR WOMEN

Do you have very painful periods?	☐ YES ☐ NO
Is your menstruation absent or erratic?	☐ YES ☐ NO
Do you have issues regarding fertility, conception or pregnancy?	☐ YES ☐ NO
Do you bleed between periods, after sex, after menopause?	☐ YES ☐ NO
Do you have a discharge which is accompanied by pain; contains blood; or has an offensive odour?	☐ YES ☐ NO

☑ WHAT SERVICE DO YOU WANT FROM US?

- ☐ Acupuncture & TCM Medicine
- ☐ Aesthetic Medicine
- ☐ Anti-aging & Rejuvenation
- ☐ Chiropractic Care
- ☐ Diet, Nutritional & Weight Management Plan
- ☐ Herbal Medicine
- ☐ Homoeopathic Medicine
- ☐ Mesotherapy & Biomesotherapy Procedures
- ☐ Naturopathic Medicine
- ☐ Pain Management Procedures
- ☐ Spinal, Joint & Mobility Procedures
- ☐ *Other……*

HAVE YOU EVER HAD….

Acupuncture / TCM treatments? If yes, date of last treatment was….	☐ YES ☐ NO
Anti-Aging / Rejuvenation treatments? If yes, date of last treatment was….	☐ YES ☐ NO
Chiropractic care? If yes, date of last treatment was….	☐ YES ☐ NO
Naturopathic care? If yes, date of last treatment was….	☐ YES ☐ NO
Osteopathic care? If yes, date of last treatment was….	☐ YES ☐ NO
Remedial Therapy? If yes, date of last treatment was….	☐ YES ☐ NO

YOUR DOCTOR DETAILS

Practice Name: ……

Address: ……

Suburb: …… Post Code: ……

Phone: …… Fax: ……

Email: ……

Does your doctor know you are here?	☐ YES ☐ NO
Would you like us to let him/her know?	☐ YES ☐ NO

IN A SENTENCE TELL ME. WHAT DO YOU WANT US TO DO FOR YOU?

……

HEALTH INSURANCE *(Please tick ☑)*

Do you have private hospital insurance?	☐ YES ☐ NO
Does your policy cover 'extras' such as Acupuncture, Naturopathy, and Natural Therapies?	☐ YES ☐ NO
Which Category are you in?	☐ Basic ☐ Intermediate ☐ High

NAME OF PERSON RESPONSIBLE FOR FEES

(PRINT) ……

PATIENT SIGNATURE *(If minor, parents must sign)*

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