Patient Profile Pre Appointment

New Patient Profile

Please fill in this information before your appointment. Filling in this information before your appointments helps save precious appointment time, minimizing basic back-and-forth questions to get you the best possible results efficiently. Completing this information at home also allows you to check information if required.

Thank you for your cooperation.

First Name: *

Last Name: *

Today's Date: *

Phone Number *

Email Address *

Date of Birth *

What is your address. Please include house number, street, suburb, postcode & state. *

Do you give permission for us to contact your GP if necessary? *

- [ ] Yes
- [ ] No

GP name, phone number & surgery

How did you hear about us? *

- ◯ Friend
- ◯ Doctor
- ◯ Pharmacy
- ◯ Other

Do you have any allergies? *

- ◯ Yes
- ◯ No

Please list any allergies if applicable

Could you be pregnant? *

- [ ] Yes
- [ ] No

Referer (Optional)

Are You Taking any Pharmaceutical Medications currently? *

- [ ] Yes
- [ ] No

If Yes Please Answer What Medication, Daily Dose & How Long You Have been taking the Medication? *

Are You Currently being Treated by another Health Practitioner? *

- ◯ Yes
- ◯ No
- ◯ Other

Please list any nutritional/ vitamin/ herbal/ dietary supplements you are taking- strength, dosage and how long you have been taking them for. For example, Biomedica Bioheme, 1 capsule daily for 6 months. *

Emergency Contact

Emergency Contact Full Name *

Emergency Contact Phone Number *

Emergency Contact Relationship to you *

Do you have mobility issues? If yes, please call or email prior to your appointment so we can make sure our space is comfortable for you. *

- ◯ Yes
- ◯ No

General Medical History

What Operations have You Had and When did you have them? Were there any Complications from them?? *

What Major Illnesseses have you had and when did you have them? *

What Childhood illnesses have you had and How Old Were You approximately? *

Have You Had Covid-19? How Many Times? *

Have you taken antibiotics in the past? If so, when was the last time and what did you take them for? *

HEAD- Please select all that apply *

- [ ] Headaches
- [ ] Migraine
- [ ] Dizziness
- [ ] Fainting
- [ ] N/A
- [ ] Other

EYES - Please select all that apply *

- [ ] Eyestrain
- [ ] Light Sensitivity
- [ ] Blurred Vision
- [ ] Watering
- [ ] Red Eye
- [ ] Painful Eye
- [ ] N/A
- [ ] Other

SKIN, HAIR, SCALP, NAILS- Please select all that apply *

- ◯ Acne
- ◯ Eczema
- ◯ Psoriasis
- ◯ Hair Loss
- ◯ Dandruff
- ◯ Excess Sweating
- ◯ Itching
- ◯ Redness
- ◯ N/A

EARS, NOSE, & THROAT- Please select all that apply *

- [ ] Deafness
- [ ] Tinitus - persistent ringing - Ear Noises
- [ ] Wax, ear aches
- [ ] Sinusitis
- [ ] Loss of sense of smell
- [ ] Blocked Nose
- [ ] Frequent Colds
- [ ] Hayfever
- [ ] Allergies
- [ ] Sneezing
- [ ] Swollen Glands
- [ ] Nose Bleeds
- [ ] N/A
- [ ] Other

MOUTH, TEETH & GUMS- Please select all that apply *

- [ ] Toothache
- [ ] Lost or loose teeth
- [ ] Abscesses
- [ ] Ulcers
- [ ] Mercury fillings
- [ ] Bleeding Gums
- [ ] Grinding teeth
- [ ] Taste Change
- [ ] N/A
- [ ] Other

DIGESTIVE SYSTEM- Please select all that apply *

- [ ] Acidity
- [ ] Burning
- [ ] Bleeding
- [ ] Indigestion
- [ ] Nausea
- [ ] Sugar Cravings
- [ ] Loss of taste
- [ ] Finger nails chip or peel easily
- [ ] Sweat has a strong odour
- [ ] Bad Breath
- [ ] Vomiting
- [ ] Bloating
- [ ] Constipation
- [ ] Diarrhea
- [ ] Hemorrhoids
- [ ] Fissures
- [ ] Change of stool colour
- [ ] Flatulence
- [ ] Excess Belching
- [ ] N/A
- [ ] Other

NECK, SHOULDERS & ARMS- Please select all that apply *

- [ ] Aching
- [ ] Tension
- [ ] Arm Pain
- [ ] Tingling, Cold hands & feet
- [ ] Joint Pain
- [ ] Numbness
- [ ] N/A
- [ ] Other

URINARY SYSTEM- Please select all that apply *

- [ ] Thirst
- [ ] Frequent going to the toilet, day or night
- [ ] Burning
- [ ] Infections
- [ ] Restricted Flow of Urine
- [ ] Change in urine colour or smell
- [ ] Blood in urine
- [ ] N/A
- [ ] Other

EMOTIONAL HEALTH- Please select all that apply *

- [ ] Depression
- [ ] Anxiety
- [ ] Restlessness
- [ ] Excess Worry
- [ ] Nightmares
- [ ] Insomnia
- [ ] Mood Swings
- [ ] N/A
- [ ] Other

NERVOUS SYSTEM- Please select all that apply *

- [ ] Weakness
- [ ] Poor Coordination
- [ ] Loss of Balance
- [ ] Memory Loss
- [ ] Difficulty Concentrating
- [ ] Numbness
- [ ] Coldness
- [ ] N/A
- [ ] Other

CHEST- Please select all that apply *

- [ ] Pains
- [ ] Tightness
- [ ] Breathing Difficulty
- [ ] Coughs
- [ ] Wheezing
- [ ] Palpitations
- [ ] N/A
- [ ] Other

FEMALE SYSTEM- Please select all that apply *

- [ ] Menstrual Irregularities
- [ ] Cramps
- [ ] PMT
- [ ] Menopause
- [ ] Hot Flushes
- [ ] Loss of Libido
- [ ] Discharges
- [ ] Infections
- [ ] Breast Lumps
- [ ] Breast Tenderness
- [ ] N/A
- [ ] Other

MALE SYSTEM- Please select all that apply *

- [ ] Erection concerns
- [ ] Lower back pain
- [ ] Sciatica
- [ ] Joint Pains
- [ ] Prostate problems
- [ ] Waking in night to urinate
- [ ] Change in urine stream- stopping/starting
- [ ] N/A
- [ ] Other