

Patient Medical History Form



Personal/contact information:

First name: Last name: Date of birth:

Mobile No. Email address

Address: Number and street: Suburb: Postcode:

Emergency contact: Name: Mobile No. Relationship:

More about you:

The reason for your visit today:

Occupation: No. of kids: Are you pregnant? Yes No Due date:

Sports and hobbies:

GP Details: * (if visiting for Physiotherapy or Osteopathy)

Name: Practice Name or Suburb:

*I consent to my practitioner contacting my GP or other relevant treating health professional.

How did you hear about Coast Health Clinic?

- | | |
|---|---|
| <input type="checkbox"/> I was referred by a family member, friend or work colleague.
Who? We'd love to thank them!
..... | <input type="checkbox"/> I did a search on Google or another search engine |
| | <input type="checkbox"/> I saw an ad on Facebook or Instagram |
| | <input type="checkbox"/> I received your flyer in my letter box |
| | <input type="checkbox"/> I drove/walked past and saw your sign out front |
| | <input type="checkbox"/> I was referred by my GP, or another health professional. |
| | <input type="checkbox"/> Something else |

Do you have or have you had any of the following (please tick)?

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Bone fracture | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Infection of the soft tissues or veins |
| <input type="checkbox"/> Joint dislocation | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Abnormal emotions | <input type="checkbox"/> Deep Vein Thrombosis (DVT) |
| <input type="checkbox"/> Ligament tear | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Gynaecological concerns | <input type="checkbox"/> Abnormal sweating/ night sweats |
| <input type="checkbox"/> Tendon tear | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> HIV/ Aids or other STD's | <input type="checkbox"/> Abnormal urine (odour, frequency, colour) |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Hot, Cold and Fever, Chills | <input type="checkbox"/> Abnormal stools (loose/constipation) |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Abnormal energy levels | <input type="checkbox"/> Allergies | <input type="checkbox"/> Abnormal thirst, appetite or taste |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Cancer | |
| | <input type="checkbox"/> Blood clots | | |

Many of our services are 'hands on'. Do you have any skin infections, bruising, wounds, eczema or any sensitive areas that your therapist/practitioner should be aware of? Yes No

Please list any **medications** you take, and why you take them: Please list **surgeries** you have had, and when you had them:

.....
.....
.....

Consent for assessment and treatment:

Signing below informs us that you have read and understood our 'adverse reactions statement', our 'cancellation policy', our 'late arrival policy', 'privacy policy' (all found on the reverse side of this document), that the medical information you have provide us is accurate and completed to the best of your knowledge, and that you consent to receiving treatment.

Signed (by a parent/guardian if under 16): **x** _____ Today's date: _____

Adverse reactions statement:

Our services are generally considered to be safe, simple, efficient and effective in the treatment of many conditions. On occasion however some patients do experience adverse reactions and we'd like you to be aware of these:

- Occasionally some patients experience muscle and joint soreness or the flair up of symptoms for several hours up to a few days following the first few treatments. This occurs whenever the function of a muscle has changed in response to a treatment - like when your muscles are sore after going to the gym for the first time in a long time. To minimise this please follow any advice your therapist/practitioner gives you. The advice given will be specific to you and your condition, and may include remaining active, undertaking specific exercises, being less active for a period of time, or dietary advice such as increasing your water intake or taking a particular supplement.

- In very rare instances (less than 1 in a million), patients who have had a pre-existing bone weakening disorder (for example, osteoporosis), or arterial disorder (for example, an aneurism), have experienced bone fractures, strokes and stroke like episodes following an upper cervical (neck) manipulation/adjustment. We have never had this occur at Coast Health Clinic.

While your therapist uses the preceding questions as a 'screen' to help identify those at risk of experiencing adverse reactions, and adjusts their treatment accordingly, no questionnaire or clinical test can identify with 100% accuracy all conditions that may result in an adverse reaction. As such, neither your therapist/practitioner, nor Coast Health Clinic, nor its directors, will be held liable for the onset of adverse reactions brought on by the existence of a pre-existing condition.

If you do experience any unexpected adverse reactions contact the clinic and ask to speak to your therapist/practitioner.

Cancelation policy:

If you cannot attend your appointment for any reason, please call us ASAP to reschedule. Please note that you are still required to pay for your appointment if you cancel your appointment with less than 4 hours notice, move your appointment to another day with less than 4 hours notice or if you fail to attend without notice.

Late arrival policy:

Please call us if you think you'll run late for your appointment- it's just polite to do so. Often, we are able to shuffle a few appointments around to accommodate you at a slightly later time. The more notice we have the easier this is.

If you are late to an appointment we may have to adjust the duration of your appointment to ensure that other clients are not inconvenienced.

Privacy policy:

Information you provide to us, be it on paper (such as this form), in consultations, via email, phone or otherwise, is stored remotely on secure data servers as per industry norms. All clinic staff have access to your information, and are entrusted to only access your information for legitimate clinical purposes. Please note that staff may, for ease of communication, contact you from their personal mobile devices, personal email accounts, or via other methods.

At times, to deliver the best care, we may suggest that we share information we have collected, our clinical notes, and/or our professional opinion with another health care provider, fitness industry provider, or sporting coach. In any such situation, we would always seek permission from you first.

By default, for most appointment types our software will email you an appointment confirmation on making a booking, and a receipt after you have made a payment. Likewise, by default, our software will send you a text the day prior to each appointment to remind you of your appointment.

From time to time, we use our software to notify patients via email or text information that may be of interest to them- for example when staff are taking and/or returning from leave, special offers and promotions, and general clinic news. If you receive an email or text from us and you'd prefer to opt-out, simply reply 'stop' and we'll remove you from the list.

Other than circumstances such as unlawful activity or serious threats to health and safety, we do not share personal information with any other business or agency. You may opt out of further contact from us at any time.