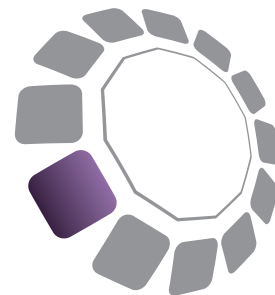


Client Information Sheet



FIRST NAME:

LAST NAME:

ADDRESS (LINE 1):

ADDRESS (LINE 2):

SUBURB:

STATE

POSTCODE

HOME PHONE:

WORK PHONE:

MOBILE:

EMAIL:

Have you ever had any of the following medical conditions? (PLEASE TICK EITHER YES OR NO IN ALL BOXES)

Blood pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Osteoporosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Osteoporosis medicine	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pacemaker	<input type="checkbox"/> YES <input type="checkbox"/> NO	Bronchitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chest pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	Breathing problem	<input type="checkbox"/> YES <input type="checkbox"/> NO	Bone problem	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cardiac surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO	Smoking	<input type="checkbox"/> YES <input type="checkbox"/> NO	Radiotherapy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bleeding disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	AIDS or HIV	<input type="checkbox"/> YES <input type="checkbox"/> NO	Chemotherapy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Rheumatic fever	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis (A,B,C)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Epilepsy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Depression	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO	Blood transfusions	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sinusitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stomach ulcer	<input type="checkbox"/> YES <input type="checkbox"/> NO	Organ transplant	<input type="checkbox"/> YES <input type="checkbox"/> NO
Snoring	<input type="checkbox"/> YES <input type="checkbox"/> NO	Thyroid problem	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other (please specify)	<input type="checkbox"/> YES

Details of other medical conditions

Condition 1: _____

Condition 2: _____

Condition 3: _____

Condition 4: _____

Condition 5: _____

Condition 6: _____

What is the purpose of your visit today?

Consultation

Treatment

- I am aware of \$100 fee of late cancellation and failing to attend Clinic policy and I understand 24 hours (for week days) and 48 hours (for weekends) notice is necessary to cancel my appointment in the courtesy of clinics and other patients right.
- I hereby accept all the responsibility for the account and I agree if my health fund does not cover my treatment for any reason, I will pay all the costs and fees involved and will claim through my health fund myself.

You will be visited by one of our medical professionals. Please inform reception about your preferred practitioner.

SIGNATURE

DATE (DD/MM/YYYY)

Thank you for choosing Central Medical.