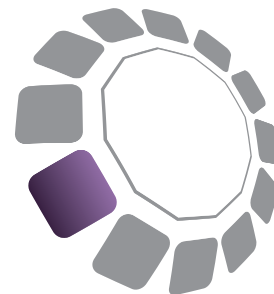
Client Information Sheet



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)

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

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 apptonment 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.