



Today's Date: _____

Name: _____

Address: _____

Phone: (H) _____

(B) _____

(M) _____

Email: _____

Occupation: _____

D.O.B: _____ **Age:** _____

Emergency Contact Details:

Name: _____

Relationship: _____

Best Contact Number: _____

Your Health:

Has any other treatment been sought for this complaint? Yes No

Have you previously had any form of manual therapy? Yes No
If so, which modality and did you have any adverse reactions? (Please list)

Do you have any medical conditions? Yes No

Please list current medications (including vitamins/supplements and anti-inflammatory medications):

Your GP's name & address:

Last Visit: _____

Permission to discuss your care and treatment with your GP/other health care providers?

Yes No Signature _____

Reason for today's visit:

How did you hear about Canberra City Osteopathy/Physiotherapy on London?

Do you take any steroid drugs?

Eg. Cortisone Yes No

Do you take any blood thinning drugs?

Eg. Warfarin or Aspirin Yes No

Have you been hospitalised or had any surgery or traumas (including broken bones & sprains) or car accidents? If so, please give details including dates

Do you have any medical implants or prosthesis? (pacemaker, metal pins, etc)

Have there been any tests/scans/x-rays for this complaint? Yes No

Do you have high blood pressure? Yes No

Have you ever had a stroke or TIA? Yes No

Family History:

Have you or anyone in your family ever suffered from: (Please circle if relevant)

Cancer	Me	Family
Heart disease	Me	Family
Circulation problems	Me	Family
Blood Clots	Me	Family
Asthma	Me	Family
Migraine	Me	Family
Liver disease/Hepatitis	Me	Family
Epilepsy/Seizures	Me	Family
Chronic Fatigue Syndrome	Me	Family
Osteoporosis	Me	Family
Incontinence	Me	Family
Urinary infections	Me	Family
Arthritis (Rheumatoid or Osteo)	Me	Family
Diabetes	Me	Family
Thyroid disease	Me	Family
Kidney disease	Me	Family
HIV/AIDS	Me	Family
Dental surgery	Me	Family
Mental Disorder (including depression)	Me	Family
Any other significant family history? (Please List)		

In the past 6 weeks, have you experienced any unusual or persistent: (please circle yes or no)

Chest pain	Yes	No
Shortness of breath/Trouble breathing	Yes	No
Cough/Wheeze	Yes	No
Heart palpitations/irregular pulse	Yes	No
Weight loss or weight gain	Yes	No
Increased thirst	Yes	No
Blood or mucus in the stool	Yes	No
Fatigue / Tiring easily	Yes	No
Headaches	Yes	No
Dizziness	Yes	No
Fainting	Yes	No
Fevers or Chills	Yes	No
Change in bowel habits	Yes	No
Change in bladder habits	Yes	No
Abdominal pain	Yes	No
Ringling in the Ears or deafness	Yes	No
Changes in Vision	Yes	No
Joint Pain or Swelling or Stiffness	Yes	No
Heartburn or Indigestion	Yes	No
Other: _____		

Lifestyle:

Do/Did you smoke? Yes No
 If yes, How much? _____
 Do you drink alcohol? Yes No
 How many glasses per week? _____
 Do/Did you use recreational drugs? Yes No
 If so, which ones? _____

Do you exercise?
 What type/How much? Yes No

Are you a vegan or vegetarian? Yes No
 Do you have any allergies? Yes No
 Details: _____

Any other comments about your health?

Men only:

Have you had any testicular problems? Yes No
 Have you had any prostate problems? Yes No
 Any pain or difficulty with urination? Yes No
 When was your last prostate exam?

Women only:

Do you take the pill? Yes No
 Do you have painful periods? Yes No
 Do you ever experience pain during intercourse?
 Always Sometimes Never
 Do you have any children? Yes No
 If so, how many? _____
 Are you pregnant? Yes No Trying
 If yes, how many weeks and when are you due?

How many pregnancies have you had?

Have you been through menopause?
 Yes No Currently
 Do you take HRT? Yes No

When was your last pap smear? _____
 When was your last breast exam? _____

Please ensure both sides of this form have been completed and then promptly return to reception before your consultation.