PRIVACY ACT (*Privacy Act 1988* & *Amendments*) & CONSENT TO THERAPY DECLARATION

I, the person nominated below on this day both request and consent Ashmore Health Centre to hold this, and any other personal information collected in the course of my interactions with Craig Berry's Ashmore Health Centre and its practitioners or representatives as a **confidential record**, and further consent to discussion and/or sharing of all relevant information limited only to those practitioners directly charged by myself with my care or in anonymous external consultation during discussion of my case for my benefit. I further warrant that I have read the *Potential Risks* section on pages nine and ten of the 'Myotherapy' Information Booklet & have personally assessed these potential risks as acceptable and consent to treatment as required. I have read and agree to the booking conditions and terms detailed on page 11 of the 'Myotherapy' Information Booklet.

Date ……./……./20___ Signature _____

☐ Reminder calls are made on the morning of an appointment. Please tick if we CAN NOT mention your appointment to the person (other than you) answering the phone number you nominate when booking.

☐ Please tick if you do not wish to receive periodicals from the Ashmore Health Centre.

PATIENT HISTORY QUESTIONNAIRE

Please read each question carefully and **complete all parts** of this questionnaire as completely and accurately as possible so that we have the most information available to understand your condition. With this information we will be best equipped to determine which techniques might be best suited to helping you; also identifying which techniques to avoid. Please print clearly to avoid confusion, thanks.

FULL Name: _____

D.O.B: ….. /……../…… Gender:.....Male ☐ Female ☐

If female, are you, or do you think you might be pregnant? **N**o / **S**uspected / **Y**es → **D**ue / /

If at any time you think you might be pregnant you MUST TELL us immediately.

Who referred you to us? _____

Your Postal Address: _____ P.Code _____

Your Phone: (h) _____ (w) _____ (m) _____

Email: _____@_____

Your Occupation Type: _____

Previous Occ: [if applicable] _____

Smoke: **N**o / **P**assive / **E**x (gave up _____) / **Y**es → I smoke on average _____ cigarettes per day

Alcohol: **N**ever / **A**verage [in standard drinks] of _____ drinks per week / month of beer / wine / spirits

Synthetic sweeteners, diet products or sugar free products at all? **N**o / **Y**es → I have _____ serves per week

Water intake: ___ litres per day **C**offee: ____cups per week **S**oft Drinks ____ litres **D**ay / **W**eek

Do you eat regularly every day? **Y**es / **N**o → I **R**egularly / **O**ccasionally skip _____ [which meal]

Do you regularly use any form of 'irregular' intoxicant? **N**o / **Y**es (we will discuss this in consultation)

Personal Physician: Dr _____ who practices in [suburb] _____

Are you currently under any other therapist's or practitioner's care? **N**o / **Y**es

if 'Yes', what are you being treated for? _____

Medical (serious) allergies? **N**o / **Y**es _____

Do you carry prescribed personal medications for emergency use? **N**o / **Y**es _____

Current (typical) regular exercise: [type of activity, since when and how many times per week] _____

_____

_____

Any other type of exercise or activity in the past? [type of activity & total years played] _____

_____

_____

ABOUT YOUR CURRENT SYMPTOMS (WHY YOU ARE HERE?)

Please describe your symptoms (the reason you are here): _____

_____

PLEASE INDICATE WHERE YOU FEEL THE MAIN FOCAL AREA/S OF PAIN EXIST IN YOUR BODY.

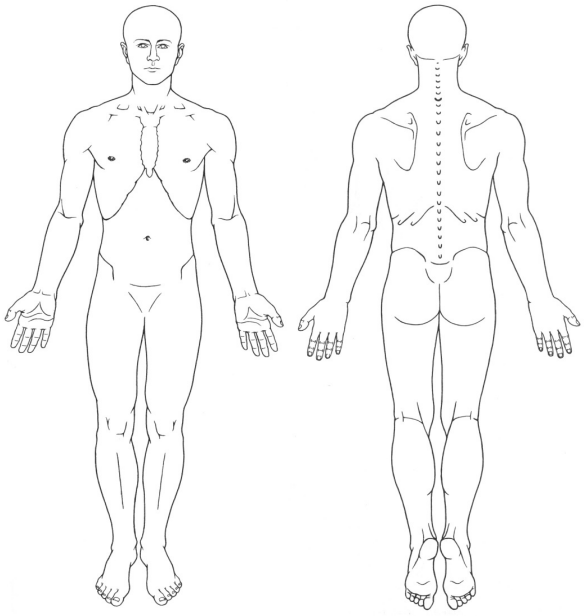
MAIN PAIN - ✖

SECONDARY PAIN - ✳

REFERRING PAIN - /////

PINS AND NEEDLES - :::::::

NUMBNESS - ###



Describe the pain or sensation (sharp, dull, burning etc.): _____

When did THIS EPISODE start? / / Has it happened before? No / Yes – first noticed around _____

Did anything in particular set off this episode? _____

Describe what originally started the problem? _____

What aggravates the problem now? _____

What relieves the problem now? _____

Is there any pattern to your problem? No / Yes _____

What treatment (and when) have you had for this complaint (was it at all successful?)? _____

_____

_____

Have you had any tests for this complaint? _____

_____

_____

Is there anything else we should know about this problem? _____

_____

_____

YOUR HISTORY IS AN IMPORTANT PART OF YOUR CONSULTATION BECAUSE SOME MEDICAL PROBLEMS CAN COMPLICATE BODY WORK, OR EVEN MAKE SOME TECHNIQUES DANGEROUS TO PERFORM.

IT IS CRITICAL THAT YOU FILL THIS SECTION OUT CAREFULLY AND COMPLETELY, READING EACH QUESTION THOROUGHLY BEFORE ANSWERING.

PLEASE LIST ANY PHARMACEUTICAL PRODUCTS YOU CURRENTLY & REGULARLY TAKE?
(OR HAVE TAKEN IN THE RECENT PAST)

Drug name	Taken since [date]	Dose	Reason for drug…

PLEASE READ CAREFULLY

ONLY TICK "YES" IF ANY OF THESE THINGS HAVE **ONLY** HAPPENED IN THE **LAST FOUR WEEKS** , NOT BEFORE AND YOU HAVE **NOT** TOLD YOUR DOCTOR ABOUT THEM OR ALREADY HAD THEM INVESTIGATED:

Only ever in the last 4 weeks		Yes	No		Yes	No	Only ever in the last 4 weeks
	Deep chest pains or abdominal pains			Shortness of breath or painful breathing			
	Dizziness or fainting spells			Pain or problems swallowing			
	Nausea or vomiting			Heart palpitations			
	Sweats or fevers			Unexplained weight change (over 3 kg)			
	Changes in toilet habits			Sharp or sudden onset headaches			
	Painful urination or bowel movements			Blood in urine, stools or phlegm			
	Rashes, skin complaints			Anything else unusual and of concern			
	Unusual Cramps or spasms			Recent trouble getting/staying asleep			

LOOKING AT YOUR **PERSONAL** MEDICAL HISTORY, DO YOU **HAVE**, OR HAVE YOU **EVER HAD**:

	Yes	No		Yes	No
Cancer - type			HIV or AIDS		
Hepatitis - type			Asthma		
Diabetes			Epilepsy or seizures		
Heart conditions or blood disorders			High blood pressure		
Any contagious or infectious conditions			Arthritis (osteo or rheumatoid)		
Regular headaches			Menstrual problems? (females only)		
Genito-urinary problems			Bowel – digestive problems		
Osteoporosis or similar degenerative prob.			Any other complaint requiring hospitalisation		

DETAILS (IF RELEVANT): _____

_____

_____

_____

_____

_____

_____

_____

ABOUT YOUR PREVIOUS INJURIES, ACCIDENTS ETC.

IT IS VERY IMPORTANT THAT SHOULD ANY OF THESE THINGS CHANGE, OR YOU SHOULD HAVE ANY THING HAPPEN MEDICALLY OR PHYSICALLY (FALLS, ACCIDENTS ETC.) BETWEEN VISITS THAT YOU LET US KNOW IMMEDIATELY, **ESPECIALLY FOR THE LADIES, IF THERE IS A CHANCE OF BEING PREGNANT**.

HAVE YOU BEEN INVOLVED IN A MOTOR VEHICLE ACCIDENT RESULTING IN INJURY? **N**O / **Y**ES

Date	Where in the vehicle were you? (driver etc.)	Were you wearing a seatbelt?	The impact was where on **YOUR** vehicle? (eg. Front on, right corner OR Left to right, rear left corner)	What injuries did you receive?

Not including anything you have told us about elsewhere on this form:

1. HAVE YOU HAD **ANY SURGERY** (THERAPEUTIC OR COSMETIC)? **N**O / **Y**ES
2. HAVE YOU HAD A WORK OR SPORTS RELATED INJURY? **N**O / **Y**ES
3. HAVE YOU HAD ANY FRACTURES, REPETITIVE INJURIES, OR OTHER SIGNIFICANT PHYSICAL INJURY? **N**O / **Y**ES

IF ANSWERING **YES** TO ANY QUESTION, PLEASE FILL IN THE DETAILS BELOW

When (year)	What happened	Any treatment (+ how long & did it work?)

IS THERE ANYTHING ELSE REGARDING YOUR PHYSICAL OR MEDICAL HISTORY THAT YOU FEEL WE SHOULD KNOW ABOUT? **N**o / **Y**es _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

