PAIN RELIEF AND WELLNESS CLINIC

INTAKE FORM

All client file and clinical information is confidential and paper based. Only name, phone number, email kept online

Name_____Private health fund_____

Referral/how did you hear about us?(eg friend, web, walk by etc)_____

Address_____ Suburb_____post code_____

Mobile No_____ email_____

Work No_____Home No_____ Date of birth_____

Occupation_____ Height _____ Weight_____

Main Complaint_____

_____

Any Formal Diagnosis(medical)_____

Background

Childhood Disease/problems/birth complications (age)_____

_____

Adult Injuries(age) _____

_____

X-ray/scans_____

Broken bones/fractures_____

Surgeries_____

Painful areas_____

What level of pain (please circle) no pain - 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 worst pain

Drugs, Medications, supplements : _____

Other treatment / therapy:_____

Exercise / Hobbies _____

Do you sleep well_____average hours_____

Diet / Food (allergies, lots of take out etc)_____

Do you have any of the following (please circle) : Infection disease, cancer, diabetes, high blood pressure, compromised / auto immune, heart disease, hepatitis, Asthma, seizures, Currently pregnant.
Comment. _____

Family history - Any health problems in blood related relatives, eg. cancer, diabetes.

_____

_____

symptom list:

Please circle ⬭ current symptoms and underline_____ ones from the past

General: Lack of energy, hyperactive, fever, insomnia, depression, anxiety, high stress levels (occupational , emotional), sweat easily, night sweats, sweaty hands and feet or anywhere else, poor concentration, localised weakness, skin - acne, rash, psoriasis, eczema, dry skin,

Musculoskeletal: Arthritis, myofascial pain syndrome, fibromyalgia, chronic fatigue, tendinitis,

Digestive: Poor appetite, Large appetite, vomiting, nausea, loose stools, diarrhoea, constipation, haemorrhoids, indigestion, gall bladder problems, excessive gas, ulcers, irritable bowel, acid reflux,

Uriniary/Reproductive: Urgency, frequency, wake to urinate, pain on urination, Kidney pain,

Female: periods-irregular-light-heavy- painful-PMS, menopause, infertility, low libido, Frequent UTI, emotional

Male: Prostate problems, impotence, low libido, infertility.

Ears, eyes, nose and reparatory: Tinnitus, vertigo, decreased hearing, blurred vision, spots in vision, eye inflammation, sinus and head cold, allergy, hay fever, teeth grinding, gum problems/bleeding, cough, asthma, lung disease, frequent respiratory infections, temporomandibular dysfunction/jaw.

Cardio vascular / Circulation: Elevated cholesterol, High / low blood pressure, blood clot, fainting, headache, migraine, pressure in chest, shortness of breath, anaemia, fast pulse (↑ 100BPM), Slow pulse (↓ 60 BPM), irregular pulse, nausea, Cold hands and feet,

Hormone/auto immune/inflammatory: low thyroid, overactive thyroid, diabetes, Crohn's disease, lupus, low immunity, colitis,

Lifestyle: Cigarettes, alcohol, marijuana, cocaine/amphetamine uppers,

Other/anything else: _____

Please note acupuncture and massage can, though rarely cause superficial bruising. After the treatment some people find they can be light headed. This is temporary only lasting a short while. Some muscular discomfort can also be present for a day or two after treatment. Any Questions please ask the practitioner.

I have disclosed my relevant details to the best of my knowledge

sign_____date:_____

I consent to Leif Tunell, on behalf of The Pain Relief & Wellness Clinic at 16 Hardie Street, Darlinghurst NSW 2010, disclosing my personal and treatment information in accordance with the Privacy and Personal Information Protection Act 1998 and the Health Records and Information Privacy Act 2002 and, in particular:
a) disclosing my personal and health/treatment information to third parties (therapists) at the Pain Relief & Wellness Clinic who may assist in my treatment, and
b) my GP and/or medical specialist (please specify)

sign_____date:_____