Mr / Mrs / Ms / Dr / Prof / Other (please circle) or other: -_____ DOB: _____

Full Name: _____ Preferred Name: _____

Address: _____Occupation: _____

Postal address if different from above: _____

Phone: _____ Mobile: _____ Email: _____

Emergency contact: _____ Phone: _____ Relationship: _____

Usual GP: _____ Are you on a pension? YES / NO – Card number_____

Medicare number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref: ___ Expiry date: ___ ___ / ___ ___ ___ ___

Private health fund: _____ Member number: _____ DVA No: _____

Is this consultation in relation to a Worker's Compensation claim? YES / NO – Insurance company: _____

Have you ever had or now have	**YES**	**NO**	**Have you ever had or now have**	**YES**	**NO**
Heart trouble	☐	☐	Reflux / Hiatus hernia / Gord	☐	☐
Heart attack	☐	☐	Bruising and or bleeding problems.	☐	☐
High blood pressure	☐	☐	Osteoporosis	☐	☐
Asthma	☐	☐	Blood clots: - Legs / Lungs (please circle)	☐	☐
Sleep apnoea	☐	☐	Kidney trouble: - Failure / Stone / Dialysis / Infection (please circle)	☐	☐
Are you, or could you be HIV positive	☐	☐	Cancer: - Type: - Year diagnosed: -	☐	☐
Fits and or epilepsy	☐	☐	Have you ever had a blood transfusion? If so, in what year:-	☐	☐
A stroke	☐	☐	Liver problem: - Cirrhosis / Jaundice Hepatitis (please circle) A B C D F G	☐	☐
Could you be pregnant?	☐	☐	Arthritis: (please circle) Rheumatoid / Osteo / Gout / Neck and or back problems	☐	☐
Diabetes: - If yes treated how is it treated: Tablet / Diet / Insulin	☐	☐	Other:-	☐	☐

Current medications: _____

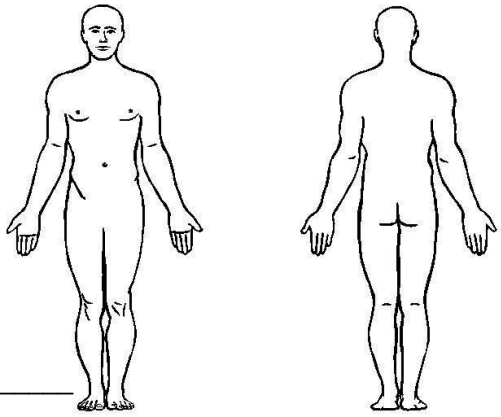
_____

_____

Allergies: _____

_____

Please circle relevant problem area



Patient sign: _____ Date: _____

ACKNOWLEDGEMENT: The information I have given on this form to A/Prof Michael Neil is true & correct to the best of my knowledge.