

# BASSENDAN WELLNESS CLINIC

## Confidential Patient form

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: \_\_\_\_\_ Sex: M F Occupation: \_\_\_\_\_

Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ Post Code: \_\_\_\_\_

PHONE: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (M) \_\_\_\_\_

Pensioner card  Healthcare card  Student card  Emergency Contact & PH: \_\_\_\_\_

Marital Status: \_\_\_\_\_ No. Children: \_\_\_\_ Health Cover: None  Private  With: \_\_\_\_\_

Reason for this visit: \_\_\_\_\_

Have you received treatment for this in the past? Yes \_\_\_\_ No \_\_\_\_

Details of past treatment (who & when): \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Is this a Work Cover or MVA claim? Y N (If yes, Please ask reception for supplementary form)

## SYMPTOM DIAGRAM

**Please show us where  
your complaint is**

BURNING XXXXX NUMBNESS OOOOO

STABBING // PINS & NEEDLES ^^^^^

IF YOU ANSWER YES TO ANY OF THE FOLLOWING QUESTIONS,  
PLEASE PROVIDE FURTHER INFORMATION:

Are you on any medication? \_\_\_\_\_ Y N

Have you had a motor vehicle accident or serious injury? \_\_\_\_\_ Y N

Have you been admitted to hospital in the past 12 months? \_\_\_\_\_ Y N

Do you have any x-rays, CT scans, MRI, Ultrasound? \_\_\_\_\_ Y N

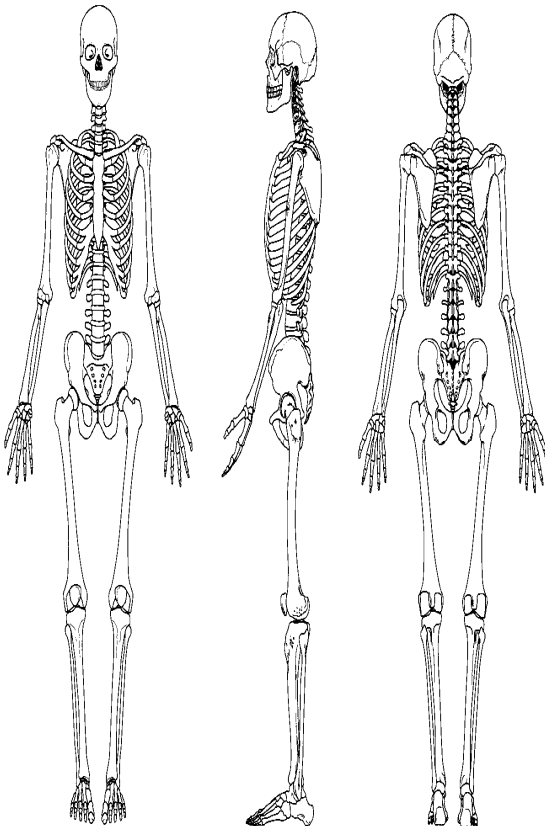
Do you have any ongoing health problems? \_\_\_\_\_ Y N

Have you had any unexplained weight loss? \_\_\_\_\_ Y N

Have you had any abnormal bleeding from any body part? \_\_\_\_\_ Y N

Have you had any recent changes in a mole or freckle? \_\_\_\_\_ Y N

Do you have any unusual lumps or swellings? \_\_\_\_\_ Y N



Anterior Skeleton

Lateral Skeleton

Posterior Skeleton

Please provide us in detail, any symptoms that you may have or any information regarding your complaint: \_\_\_\_\_

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## SYSTEMS REVIEW HISTORY

Please circle Yes or No to the following questions about your general health. This information will give us a more complete understanding about your body's overall function.

Headaches	Y N	Neck pain	Y N
Dizziness	Y N	Neck stiffness	Y N
Blurred vision	Y N	Mid back pain	Y N
Ring / buzz in ears	Y N	Chest pain	Y N
Difficulty swallowing	Y N	Palpitations	Y N
Loss of consciousness	Y N	High blood pressure	Y N
Numbness in any body part	Y N	Low blood pressure	Y N
Weakness in any body part	Y N	Heart trouble	Y N
Stroke	Y N	Difficulty breathing	Y N
Depression	Y N	Low back pain	Y N
Nervousness	Y N	Stomach trouble	Y N
Sleeping problems	Y N	Indigestion	Y N
Energy loss	Y N	Liver problems	Y N
Morning tiredness	Y N	Colon problems	Y N
Fainting feeling	Y N	Diabetes	Y N
Sinus problems	Y N	Kidney / bladder problems	Y N
Allergies	Y N	Poor circulation	Y N
Lower limb problems	Y N	Upper limb problems	Y N
Are you a smoker?	Y N	Pregnancy- past/ present	Y N

Other: \_\_\_\_\_

Relevant Family History: \_\_\_\_\_

Please rate the severity of your pain at the moment by circling number(s) below on the following scale:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (extreme Pain)