CONFIDENTIAL PATIENT REGISTRATION FORM

MR / MRS/ MS/ MISS/ MASTER/ DR

SURNAME_____

GIVEN NAME(s)_____

POSTAL ADDRESS_____

_____**POSTCODE**_____

Telephone: **(Work)**_____

(Home)_____

(Mobile)_____

(Email)_____

Date Of Birth_____ **AGE**_____ **Gender: M / F**

Occupation_____ **Employer** _____

Next of Kin_____ **Phone No** _____

Private Health Fund_____ **Membership No**_____ **Position on card**____ **Exp Date** _____

Medicare No_____ **Medicare Ref No**_____ **Exp Date** _____

Please circle: Pensioner / DVA / Health Care Card **No**_____ **Exp Date** _____
If DVA please circle gold / white / orange

Family Doctor _____

Clinic Name_____

Is this a Workcover / ICWA / Sports Club or other Insurance Claim? **YES / NO**

How did you discover our clinic? (Please circle) Sporting Club please specify_____

Friend / Family / Hospital / Driving Past / Yellow Pages / Internet / Other_____

Signed_____ **Date** _____/_____/_____

PLEASE NOTE: THIS IS A PRIVATE PRACTICE AND FEES ARE PAYABLE AT THE TIME OF CONSULTATION. SHOULD PAYMENT OF THESE FEES PRESENT A PROBLEM, PLEASE DISCUSS THIS WITH THE STAFF AND NOTIFY THE OFFICE PRIOR TO YOUR CONSULTATION IF YOU REQUIRE CONSIDERATION.

THERE IS A $25 CANCELLATION FEE FOR APPOINTMENTS CANCELLED WITH LESS THAN 24 HOURS' NOTICE

***HICAPS & EFTPOS FACILITIES AVAILABLE**

Nutritional Medicine Questionnaire

Full Name: _____ Date of Birth: _____ Date: _____
Please write briefly the main reason for attending the clinic:

Please list your current symptoms or health concerns:

What treatment has helped so far and what has not?

Are you seeing any other practioners (Doctors/allied health, alternative practitioners) and would you like Dr Jen to communicate with them regarding your care?

Please briefly answer the following:
Are there any diseases that run in your family? (mental health problems, diabetes, asthma, cancer, arthritis)

Did you have any early health issues or developmental issues?

Please list any current medical issues:

Important past medical issues or surgery?

What prescription drugs are you currently taking?

What medications have you taken in the past? What did not work, or caused a bad reaction?

What supplements/vitamins/minerals/herbs are you taking?

Do you smoke? How much?
Do you drink alcohol? How often/how much?
Do you take any other drugs? How often/how much?

What is your blood group?

Briefly describe your diet: are there any foods you avoid or any you particularly like?

Any allergies, reactions to food or medications, chemical sensitivities?

Have you ever been pregnant? Any problems during or after pregnancy, including postnatal depression/anxiety?

What exercise/sports do you enjoy and how much do you exercise?

Briefly, where did you grow up and where have you lived?

What is your current occupation?
Please list your previous occupations:

Have you had any significant exposure in the past to heavy metals (mercury, others), chemicals (including pesticides, cleaning products, hair/cosmetic products, solvents, others?

Any hobbies?

Topic	Have you had:	Never	In the past	Recently	Frequently
Digestion	Heartburn/reflux				
	Bloating				
	Constipation				
	Burping/wind				
	Diarrhoea/loose stools				
	Nausea				
	Stomach pains				
	Gall bladder problems				
	Leaky gut				
Lungs	Asthma/emphysema				
	Pneumonia/bronchitis				
Immune system	Skin infections				
	Ear/sinus/throat infections				
	Thrush				
	Urinary infections				
	Other infective diseases				
Hair/skin/nails	Acne				
	Nail changes				
	Dry skin/eyes/mouth				
	Eczema/dermatitis				
	Hair changes				
	Other rashes				
Gynaecology	Abnormal PAP smears				
	Breast symptoms				
	Endometriosis				
	Ovarian cysts				
	PMS/PMT				
	Oral contraceptive use				
	HRT use				
Urinary	Prolapse, incontinence				
	Kidney stones				
Liver	Abnormal liver tests				
	Jaundice				
	Hepatitis				
Heart	Chest pains				
	Cold hands/feet				
	Fluid retention				
	High blood pressure				
	Palpitations				
Sleep	Insomnia/disturbed sleep				
	Snoring				
	Sleep apnoea				
Nervous system	Anxiety				
	Blurred vision				
	Chronic pain				
	Depression				
	Dizziness				
	Restlessness				
	Seizures				
	Cramps				
	Poor balance				
	Memory loss				
	Trouble concentrating				
	Headaches				
	Mood swings/irritability				
	Weakness				

	Tingling or numbness				
	Tinnitus				
	Tremor				
Blood	Easy bruising				
	Anaemia				
	Blood clots				
Cancer	Type:				
Arthitis, autoimmune	Osteoarthritis				
	Rheumatoid arthritis				
	Spondyloarthritis/other				
	Gout				
	Lupus				
	Thyroid problems				
	Diabetes				
	Chronic fatigue syndrome				
	Fibromyalgia				

Checklist for mental health symptoms: Please tick any of the following which apply to you.

Pyrroluria	Poor stress control/tolerance	
	Anxiety/panic/fear/anger	
	Rapid mood changes	
	Easily fatigued	
	Morning nausea	
	Motion sickness	
	Severe depression	
	Irritability	
	Sensitive to noise/light/smells	
	Poor dream recall	
	Poor short term memory	
	Like spicy food	
	Behaviour or learning disorders	
	Paranoia	
	Impulsivity, hyperactivity	
	Food and chemical sensitivities	
	Tend to skip breakfast	
	Pale skin, doesn't tan easily	
	Frequent infections	
	Poor growth	
	Early greying	
	Stretch marks	
	Poor muscle development	
	Acne	
	Delayed puberty	
	Violence, loss of control	
	Dry skin	
Copper Excess	Hot sweats	
	Tinnitus	
	Menopausal issues	
	React to contraceptive pill/HRT	
	Endometriosis/fibroids	
	High anxiety/depression	
	Sensitive skin	
	Emotional meltdowns	
	Arthritis	
Undermethylation	Self-motivated	
	High achiever	
	Strong willed/stubborn	
	High Motivation/inflexible	
	High libido	
	Perfectionist/procrastinater	
	Migraines	
	Addictive behaviour	
	Calm demeanour: but high inner tension/anxiety	
	Low pain tolerance	
	Sparse hair growth	
	Insomnia but needs little sleep	
	Delusions	
	Phobias/risk taking	
	Obsessive/compulsive traits	
	Social Isolation	
	Recurrent negative thoughts	
	Fast metabolism	
	Heat intolerant	

	Seasonal allergies	
	Eating disorders	
	Sudden breakdown	
	Easy tearfulness	
	Collecting things	
	Computer or work addiction	
	Hears pulse in ears at night	
	Slender build	
Overmethylation	Poor achiever	
	Poor motivation, often late	
	Artistic/musical ability	
	High anxiety/panic	
	Low libido	
	Fatigue	
	Overweight or obese	
	Stuttering	
	Easily frustrated	
	Sleep disorder	
	Paranoia/obsessions	
	Depression	
	Self-harm	
	Rarely catches a cold	
	Self-isolation	
	Nervousness	
	Tinnitus/racing thoughts/hallucinations	
	Hirsute/Hairy	
	Food/chemical sensitivities	
	High pain threshold	
	Stubby fingers	
	Young looking body	
	Eczema/dry skin	
	Slow metabolism	
	Restless, nervous legs	
	React badly to anti-histamines and anti-depressants	
	ADHD	

Please read the two consent forms attached and sign if you are comfortable doing so. If you have any concerns please discuss this with Dr Jen in your appointment before signing.

NAME OF PATIENT: _____DATE:_____

CONSENT STATEMENT

Our practice is committed to providing you with quality, continuing care, including the protection of the confidentiality of your records. As part of this care and in compliance with the Privacy Legislation, it is important that we gain your consent to collect and use personal information about you, only as necessary. Our practice has a Privacy Policy on the collection, use, disclosure and security of information obtained from our patients.

I hereby acknowledge that health information is required to be collected by the clinicians at South Coast Sports Medicine to provide me with effective and appropriate health care management.

I consent to and authorise the collection of such information by the practitioners of South Coast Sports Medicine and I agree that my medical records may be retained and utilised by the health professionals at South Coast Sports Medicine for the purpose of future health care treatment and or management.

I consent to information regarding my condition, treatment and management being given to and received by doctors, other treatment providers, hospital, pathology, radiological services and or one of the following third party bodies - Please circle the appropriate third party ie.: Workcover, ICWA, Insurance Company, or nominate:

_____

I/We understand and agree to be bound by the Consent Statements and the Financial Terms and Conditions set out herein.

Signed……**(Patient)** **Date**……

Signed……**(Parent/Guardian)** **Date**……

I am aware fees are payable at the time of consultation and that there is a $25 cancellation fee if I cancel an appointment with less than 24 hours' notice.

Signed……**(Patient)** **Date**……

Signed……**(Parent/Guardian)** **Date**……

Witness…… **Date**……

Consent form for patients receiving Functional Medicine treatment

I _____, date of birth_____

understand that:

- Functional Medicine is an approach that combines conventional and complementary medicine. Some of the diagnostic tests, treatments and products prescribed may be outside the parameters of conventional medicine in Australia.
- Although Functional Medicine has been used as an effective therapy, it is still considered an unconventional form of treatment by many in Australia.

I understand that Dr Graham-Taylor will provide me with sufficient information to make an informed decision about the range of options for both Functional Medicine treatment and treatment using conventional medicine to help me make an informed choice.

Dr Graham-Taylor will inform me which treatments are supported by empirical and/or scientific knowledge, and of any known risks associated with treatment.

I acknowledge that information, data and drug/herb/supplement interaction databases are constantly updated as new research becomes available, and due to the evolving nature of this field unforeseen complications and risks may eventuate.

I would like to take responsibility for my health care and to participate as a partner in any decision making. I acknowledge the importance of lifestyle and prevention in maintaining good health.

I understand that some of the recommended tests and treatments may not be covered by Medicare or private health insurance funds, and I will be informed of approximate costs at the time of my consultation.

I understand that the supplements that Dr Graham-Taylor recommends are sometimes not approved by the Therapeutic Goods Association.

By signing this document, I acknowledge that I have read and understood the information on this form.

Signature: _____

Date: _____

Witness: _____