Name: _____Date of Birth_____

Address: _____

Suburb: _____Postcode: _____

Phone (M): _____E-mail:_____Occupation: _____

Do you have private health insurance (Yes/No)? If yes, who is your private heath provider?_____

Medical History

Do you have or have you ever had any of the following conditions? (Please tick)

High/low blood pressure		Pacemaker		Headaches/Migraines	
Spinal disorders		Heart conditions		Head injury/Concussion	
Varicose Veins		Asthma/Respiratory disorder		Irritable bowel syndrome	
Thrombosis / blood clots		Diabetes		Arthritis	
Recent fractures		Cancer		Skin Disorders	
Inflammation		Fibromyalgia		Pregnant	

Are you taking any medication? (If yes, please list them) : _____
_____

Briefly, what are your main reasons for seeking treatment today?_____
_____
_____

How would you describe your pain?_____

_____

What aggravates your pain?_____

What eases your pain? _____

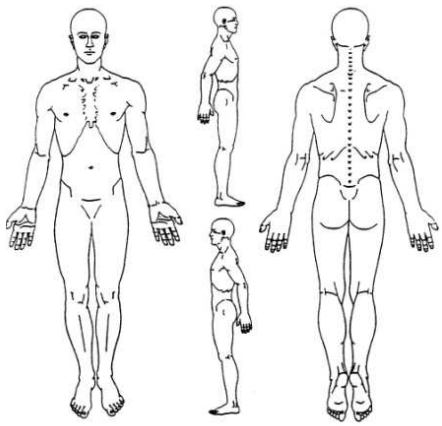
How frequent is the pain?_____

Has the pain caused any changes to your daily living?_____

Have you had any previous radiology scans and/ or tests?_____

Is there anything else we should know?
_____
_____

Whom may we thank for referring you? _____



I have read and completed the above and certify it is true and correct to the best of my knowledge. I will notify you of any changes to my health status of the information above.

Cancellation Policy: Please note that a cancellation fee of 50% will apply if less then 24hours notice is given.

Singature: _____ Date: _____