

**PRIVACY ACT (Privacy Act 1988 & Amendments) & CONSENT TO THERAPY DECLARATION**

I, the person nominated below on this day both request and consent Ashmore Health Centre to hold this, and any other personal information collected in the course of my interactions with the Ashmore Health Centre and its practitioners or representatives as a **confidential medical record**, and further consent to discussion and/or sharing of all relevant information limited only to those practitioners directly charged by myself with my care or in anonymous external consultation during discussion of my case for my benefit. I further warrant that I have read the *Potential Risks* section on pages nine and ten of the 'Myotherapy' Information Booklet, have assessed these potential risks as acceptable and consent to treatment as required. I have read and agree to the booking conditions and terms detailed on page 11 of the 'Myotherapy' Information Booklet.

Date ...../...../20..... Signature \_\_\_\_\_

- Reminder calls are made on the morning of an appointment. Please tick if we CAN NOT mention your appointment to the person (other than you) answering the phone number you nominate when booking.
- Please tick if you do not wish to receive periodicals from the Ashmore Health Centre.

**PATIENT HISTORY QUESTIONNAIRE**

**Please read each question carefully and complete all parts** of this questionnaire as completely and accurately as possible so that we have the most information available to understand your condition. With this information we will be best equipped to determine which techniques might be best suited to helping you and also which techniques to avoid.

FULL Name: \_\_\_\_\_

D.O.B: ...../...../..... Gender:.....Male  Female

If female, are you, or do you think you might be pregnant? **No / Suspected / Yes → Due / /**  
**If at any time you think you might be pregnant you MUST TELL us immediately.**

Who referred you to us (name)? \_\_\_\_\_

Your Postal Address: \_\_\_\_\_ P.Code \_\_\_\_

Your Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (m) \_\_\_\_\_

Your Occupation: \_\_\_\_\_

Previous Occ: [if applicable] \_\_\_\_\_

Smoke: **No / Passive / Ex** (gave up \_\_\_\_\_) / **Yes** → I smoke on average \_\_\_\_\_ cigarettes per day

Alcohol: **Never / Average** [in standard drinks] of \_\_\_\_\_ drinks per week / month of beer / wine / spirits

Synthetic sweeteners, diet products or sugar free products **at all?** **No / Yes** → I have \_\_\_\_\_ serves per week

**Water intake:** \_\_\_\_ litres per day **Coffee:** \_\_\_\_ cups per week **Soft Drinks** \_\_\_\_ litres **Day / Week**

Do you eat regularly every day **Yes / No** → I **Regularly / Occasionally** skip \_\_\_\_\_ [which meal]

Do you use any form of recreational drug **No / Yes** → Type \_\_\_\_\_

Average uses per week \_\_\_\_\_

Personal Physician: Dr \_\_\_\_\_ who practices in [suburb] \_\_\_\_\_

Are you currently under any other therapist's or practitioner's care? **No / Yes**

Medical (serious) allergies? **No / Yes** - \_\_\_\_\_

Current (typical) regular exercise: [type of activity, since when and how many times per week] \_\_\_\_\_

Any other type of exercise or activity in the past? [type of activity & total years played] \_\_\_\_\_

### ABOUT YOUR CURRENT SYMPTOMS (WHY YOU ARE HERE?)

Please describe your symptoms (the reason you are here): \_\_\_\_\_

PLEASE INDICATE WHERE YOU FEEL THE MAIN FOCAL AREA/S OF PAIN EXIST IN YOUR BODY.

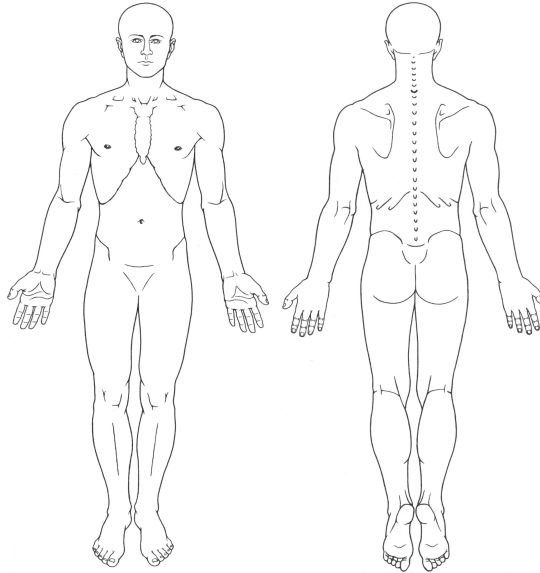
MAIN PAIN - ✕

SECONDARY PAIN - \*

REFERRING PAIN - /////

PINS AND NEEDLES - :::::

NUMBNESS - ###



Describe the pain or sensation (sharp, dull, burning etc.): \_\_\_\_\_

When did **THIS EPISODE** start? / / Has it happened before? No / Yes – originally / /

Describe what triggered the problem? \_\_\_\_\_

What aggravates the problem? \_\_\_\_\_

What relieves the problem? \_\_\_\_\_

Is there any pattern to your problem? No / Yes \_\_\_\_\_

What treatment (and when) have you had for this complaint (was it at all successful)? \_\_\_\_\_

Have you had any tests for this complaint? \_\_\_\_\_

Is there anything else we should know about this problem? \_\_\_\_\_

**YOUR HISTORY IS AN IMPORTANT PART OF YOUR CONSULTATION BECAUSE SOME MEDICAL PROBLEMS CAN COMPLICATE BODY WORK, OR EVEN MAKE SOME TECHNIQUES DANGEROUS TO PERFORM.**

**IT IS CRITICAL THAT YOU FILL THIS SECTION OUT CAREFULLY AND COMPLETELY, READING EACH QUESTION THOROUGHLY BEFORE ANSWERING.**

PLEASE LIST ANY PHARMACEUTICAL PRODUCTS YOU CURRENTLY & REGULARLY TAKE?  
(OR HAVE TAKEN IN THE RECENT PAST)

Drug name	Taken since [date]	Dose	Reason for drug...

TICK "YES" ONLY IF THESE THINGS HAVE HAPPENED IN THE **LAST FOUR WEEKS** AND **NOT BEFORE** AND YOUR DOCTOR HAS **NOT** PREVIOUSLY BEEN TOLD ABOUT OR INVESTIGATED THESE THINGS:

	Yes No			Yes No		Only in the last 4 weeks
	Yes	No		Yes	No	
Only in the last 4 weeks	<input type="checkbox"/>	<input type="checkbox"/>	Deep chest pains or abdominal pains	<input type="checkbox"/>	<input type="checkbox"/>	Only in the last 4 weeks
	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	Sweats or fevers	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	Changes in toilet habits	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination or bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	Rashes, skin complaints	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	Unusual Cramps or spasms	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath or painful breathing	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	Pain or problems swallowing	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight change (over 3 kg)	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Sharp or sudden onset headaches	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine, stools or phlegm	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Anything else unusual and of concern	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Recent trouble getting/staying asleep	<input type="checkbox"/>	<input type="checkbox"/>		

LOOKING AT YOUR **PERSONAL** MEDICAL HISTORY, DO YOU **HAVE**, OR HAVE YOU **EVER HAD**:

	Yes No			Yes No	
	Yes	No		Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer - type	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis - type	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart conditions or blood disorders	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any contagious or infectious conditions	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Regular headaches	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genito-urinary problems	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis or similar degenerative prob.	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (osteo or rheumatoid)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems? (females only)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel – digestive problems	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any other complaint requiring hospitalisation	<input type="checkbox"/>	<input type="checkbox"/>

DETAILS (IF RELEVANT): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## ABOUT YOUR PREVIOUS INJURIES, ACCIDENTS ETC.

IT IS VERY IMPORTANT THAT SHOULD ANY OF THESE THINGS CHANGE, OR YOU SHOULD HAVE ANY THING HAPPEN MEDICALLY OR PHYSICALLY (FALLS, ACCIDENTS ETC.) BETWEEN VISITS THAT YOU LET US KNOW IMMEDIATELY, **ESPECIALLY FOR THE LADIES, IF THERE IS A CHANCE OF BEING PREGNANT.**

HAVE YOU BEEN INVOLVED IN A MOTOR VEHICLE ACCIDENT RESULTING IN INJURY? **No / Yes**

Date	Where in the vehicle were you? (front driver etc.)	Were you wearing a seatbelt ?	The impact was where on <b>YOUR</b> vehicle? (eg. Front on, right corner OR Left to right, rear left corner)	What injuries did you receive?

Not including anything you have told us about elsewhere on this form:

1. HAVE YOU HAD ANY THERAPEUTIC OR COSMETIC SURGERY? **No / Yes** – PLEASE FILL IN THE DETAILS BELOW
2. HAVE YOU HAD A WORK OR SPORTS RELATED INJURY? **No / Yes** – PLEASE FILL IN THE DETAILS BELOW
3. HAVE YOU HAD ANY FRACTURES, REPETITIVE INJURIES, OR OTHER PHYSICAL INJURY? **No / Yes**

If **YES**, PLEASE FILL IN THE DETAILS BELOW

When (year)	What happened	Any treatment (+ how long & did it work?)

IS THERE ANYTHING ELSE REGARDING YOUR PHYSICAL OR MEDICAL HISTORY THAT YOU FEEL WE SHOULD KNOW ABOUT? **No / Yes** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_