I have been made aware of the Teachers Health Privacy Notice and agree to the collection and use of my personal and sensitive information as outlined therein.

Patient signature _____

The Privacy Notice is available at each Health Centre or by visiting teachershealth.com.au/privacy

THERAPIES

Personal Details

Title _____ First name _____ Surname _____

Date of birth _____ Preferred name _____

Health fund _____ Member number _____ Occupation _____

Contact Details

House/ unit _____ Street name _____ Suburb _____

State _____ Postcode _____ Email _____

Home phone _____ Mobile phone _____ Other _____

Emergency contact _____ Relationship _____ Phone _____

How did you hear about us?

- ○ Family/ Friend
- ○ I already use Eyecare/ Dental
- ○ Website
- ○ Union Advertisement
- ○ Staff member
- ○ Teachers Health Mailer
- ○ Walking by
- ○ Other _____

Medical Information

Do you have or have you had any of the following medical conditions? *(Please tick Yes or No)*

For all medical conditions marked as 'Yes' please consult your practitioner during your appointment.

Y	N	Cardiovascular disease	Y	N	Diabetes, type	Y	N	Liver disease/ problems
Y	N	High blood pressure	Y	N	Musculoskeletal	Y	N	Auto immune disorders
Y	N	Excessive bleeding	Y	N	Gastro intestinal problems	Y	N	Respiratory illness
Y	N	Rheumatic fever	Y	N	Urogenital problems	Y	N	Thyroid problems
Y	N	Infectious diseases	Y	N	Nervous system disorders	Y	N	**Women only** Pregnant? Due .....

Other .....

Y	N	I have recently been admitted to hospital or had an operation. Date .....
Y	N	I am, or have recently undergone chemotherapy or radiation therapy. Date .....
Y	N	I am allergic to .....

Medications *(please list)* .....

.....

Have you ever:

- ○ Been unconscious
- ○ Had major surgery
- ○ Been hospitalised
- ○ Been in a car accident
- ○ Broken bones

Details: .....

Would you like your practitioner to report back to your Doctor? ○ No ○ Yes *(if Yes, please provide GP's details)*

Doctor..... Phone .....

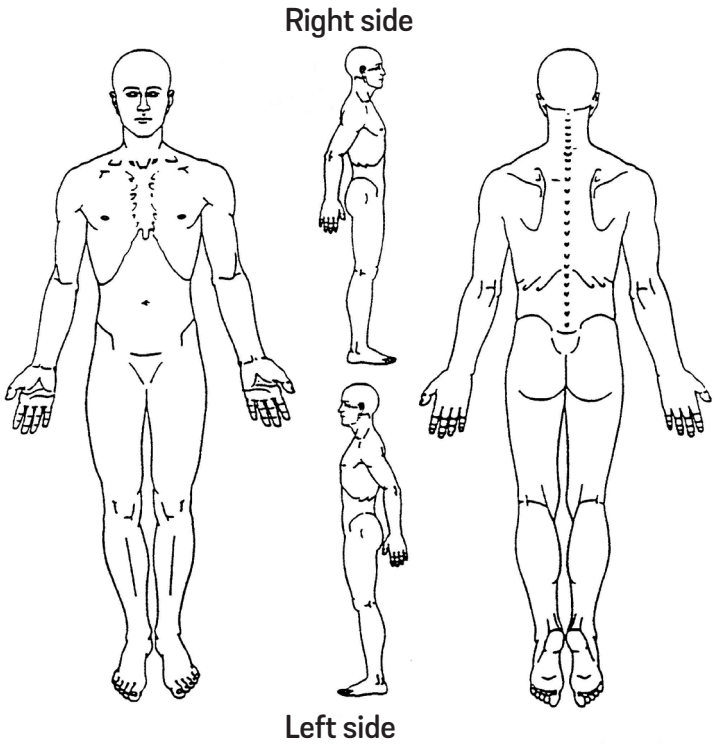
Clinic ..... Address .....

What area is your key injury/ complaint?

○ Head	○ Shoulder	○ Hip
○ TMJ	○ Elbow	○ Knee
○ Neck	○ Wrist	○ Foot
○ Cervical Spine	○ Hand	○ Ankle
○ Upper Back	○ Lower back	○ Full Body

Other: _____

Mark with an X areas of pain/ discomfort



Date of injury (exact day or weeks, months, years)

_____

Have you had X–rays/ CT scans/ MRI taken of the injury?

_____

Have you seen other practitioners for this complaint?
(and was it effective?)

_____

Do you currently have pain? Yes No

What level is your pain? (Please mark on scale below, 0 = No Pain, 10 = the most pain)

0	1	2	3	4	5	6	7	8	9	10

What type of pain are you experiencing?

○ Sharp (like a knife)	○ Throbbing	○ Shooting/ Electrical
○ Aching	○ Dull	○ Other .....

Have you experienced any:

○ Numbness	○ Heat	○ Loss of strength in any muscles of the leg
○ Pins & needles	○ Coldness	○ Loss of strength in the arm
○ Loss of strength in your grip		

When is your pain at its worst?

○ Sitting	○ Standing	○ In the morning – when you wake up
○ Bending	○ Lifting or reaching	○ At night – after work/ school

Other: .....

Is your pain:

○ Increasing	○ Decreasing	○ Staying the same
○ Constant	○ Comes and goes	○ Triggered – only after a movement

What outcomes are you expecting from your treatment? *(E.g. reduced pain, better sleep, increased movement)*

_____

I acknowledge that the medical information I have provided is true and accurate at the date of my appointment and I have disclosed any medications or conditions that may affect or influence my treatment. Payment on the day of treatment is required. I acknowledge that failure to attend any appointment without notice may also result in a deposit requirement prior to future appointments being scheduled.

Patient signature: _____ **Practitioner:** _____
(print name)

Date: _____ **Signature:** _____