Client Submission Form

Personal Details

First Name:

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Master ☐ Professor ☐ Mx

First Name:

Last Name:

Preferred Name:

Date of Birth:

Email:

Health Information

Are you currently taking any medication?

Is there a chance you could be pregnant?

Do you have any family history of serious illness or diseases?

Do you exercise regularly?

Do you have or have you ever had any of the following health conditions? (tick all that apply)

☐ Asthma ☐ Heart condition ☐ High blood pressure ☐ Diabetes ☐ Anxiety ☐ Stress

☐ Eyesight problems ☐ Joint or muscle injuries ☐ Back or neck pain

☐ Concussion or head injury ☐ Recent surgery or fracture ☐ Allergies ☐ None of the above

Do you drink alcohol? (units per week)

Do you smoke cigarettes? (per day)

Do you drink coffee or tea? (per day)

What type of pain is it?

How long have you had this condition?

Can you rate your level of pain? 1 = least painful & 10 = most painful

Health History

Have you suffered from any unexplained weight changes?

Have you ever had any car accidents?

Have you ever had any serious falls or broken bones?

Have you ever had any serious sports injuries?

General

GP Surgery / Doctor's Name:

Do you have private healthcare (BUPA, AXA, PPP, etc.)?

Personal Details

Do you have any children? If so, how many?

What services are you visiting the clinic for?

Presenting Complaint

What are you experiencing symptoms of your presenting complaint?

What type of pain is it?

Additional Notes

Message / Notes:

Declaration & Signature

I confirm that all the information I have provided on this form is correct and complete to the best of my knowledge.

Signature:

Printed Name:

Date: