AM HEALTH & PERFORMANCE

Date:

Initial Consultation Form

Patient Information

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Master.	Full Name:		Martial Status(Circle): *Single/Married/Divorced/Separated/Widow*
Country of Birth:	D.O.B	Age:	☐ Male ☐ Female
Occupation:			
If patient Under 18, Name of Parent/Guardian:		Relationship:	
Home Address:			Postcode:
Phone (H)	Phone (M)	Phone (W):	
Email address:			
Emergency Contact Name:		Relationship:	Phone:
Health Fund:	Member No:		Ref No:
Medicare No:		Ref No:	Expiry.
Referred to Clinic by:		☐ GP/Health Professional ☐ Website ☐ Family/Friend ☐ Other	
Family members seen at clinic:			

Medical Information

Current GP:	Clinic:
Last Visit: / /	GP Phone (if known):
Is your injury as a result of a work or motor vehicle accident? ☐ Yes ☐ No	
Hospitalisations &/or Surgeries:	
Accidents & Trauma:	

Current Medications:	Family History of Illness: ☐ No ☐ Yes (If yes tick below)
	☐ Cancer ☐ High Blood Pressure ☐ Diabetes ☐ Arthritis ☐ Stroke ☐ Heart Attack ☐ Seizures/Convulsions ☐ Mental Illness
	☐ Other:
Do you smoke? ☐ No ☐ Yes: How much? /Day	Do you drink? ☐ No ☐ Yes: How much? /Week
Do you Exercise? ☐ No ☐ Yes: How much? /Week	What Exercise?
What are your stress levels like (1 minimal – 10 major/Burnout): Work ( ) Home ( ) Financial ( ) Other ( )	

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0432 347 976

Presenting Complaint

Please describe your injury:

When did this problem start?

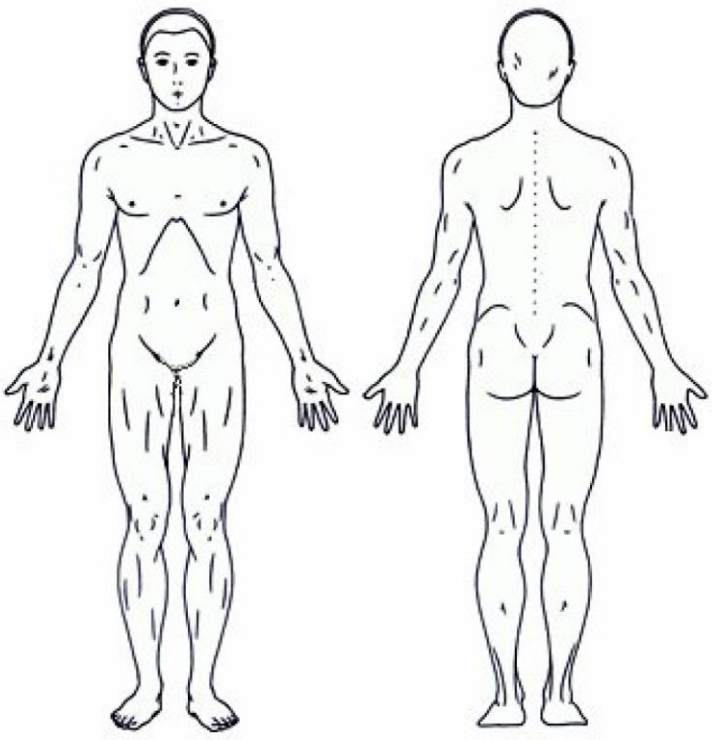
What were you doing?

What makes it better?	What makes it worse?

Describe the feeling/sensation of this injury: (Please tick/circle):

☐Sharp Pain ☐ Dull Pain ☐ Ache ☐ Throbbing ☐ Weakness ☐ Shooting Pain
☐ Numbness ☐ Burning ☐ Gripping ☐ Tingling (pins/needles)

Please mark on diagram where you feel pain/symptoms:



Are your symptoms:
☐ Increasing
☐ Decreasing
☐ Not Changing

How Frequent is your pain:
☐ Constant
☐ Intermittent
☐ Occasional
☐ Rare

Please indicate any other associated symptoms:

……

……

……

……

On a Scale from 0 to 10, how would you rate your current pain: *(please circle)*

(no pain) **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** *(unbearable)*

My symptoms are affecting: ☐ General Activities ☐ Leisure ☐ Sport ☐ Work ☐ Other (please indicate below)

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Systems Review

Do you, or have you ever had any of the following (please tick)

General

- ☐ Unexplained weight loss
- ☐ Excessive fever
- ☐ Prolonged fever/chills
- ☐ Night sweats
- ☐ Difficulty sleeping
- ☐ Allergies
- ☐ Other:

Head/EENT

- ☐ Headaches
- ☐ Migraines
- ☐ Jaw/Dental Pain
- ☐ Wear glasses/contacts
- ☐ Chronic nasal discharge/sneezing
- ☐ Impaired vision
- ☐ Impaired hearing
- ☐ Ear infections
- ☐ Recent eye examination
- ☐ Recent ear examination
- ☐ Other:

Gastrointestinal

- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Loss of appetite
- ☐ Change of bowel habits
- ☐ Blood in stools
- ☐ Haemorrhoids or rectal disease
- ☐ Other:

Respiratory

- ☐ Chronic cough
- ☐ Asthma or wheezing
- ☐ Shortness of breath
- ☐ Shortness of breath at night
- ☐ Other:

Cardiovascular

- ☐ Any Heart Trouble
- ☐ Pain or pressure in chest
- ☐ Angina
- ☐ Rheumatic Fever
- ☐ Palpitation or pounding of heart
- ☐ Swelling of ankles
- ☐ High Blood Pressure
- ☐ Other:

Haematological/Lymphatic

- ☐ Anaemia
- ☐ Excessive bleeding or bruising
- ☐ Blood transfusion
- ☐ Any swelling of lymph glands
- ☐ Other:

Neurological

- ☐ Concussion
- ☐ Memory loss
- ☐ Fainting/dizziness/convulsions
- ☐ Slurred speech
- ☐ Other:

Skin/Breast

- ☐ Change or new growth in mole
- ☐ Breast lump
- ☐ Nipple discharge
- ☐ Other:

Genitourinary

- ☐ Frequent urination at night
- ☐ Frequent or painful urination
- ☐ Difficulty holding urine
- ☐ Difficulty stopping/starting urine flow
- ☐ Urinary tract infection
- ☐ Other:

Endocrine

- ☐ Cold or heat intolerance
- ☐ Excessive thirst or hunger
- ☐ Trouble losing weight
- ☐ Other:

Musculoskeletal

- ☐ Pain in joints/arthritis
- ☐ Red inflamed joints
- ☐ Chronic back pain or injury
- ☐ Other

Female

- ☐ Mid-cycle bleeding
- ☐ Unusual vaginal discharge
- ☐ Painful periods
- ☐ Inconsistent menstrual cycles
- ☐ Premenstrual pain
- ☐ Pain with intercourse
- ☐ Pregnant or have been pregnant
- ☐ Other:

Male

- ☐ Sore or discharge from penis
- ☐ Lump or pain on testicle
- ☐ Sexual dysfunctions
- ☐ Other:

Psychological/Emotional

- ☐ High stress levels
- ☐ Are you often depressed
- ☐ Are you often anxious/nervous
- ☐ other:

Signed: **Date:**

Guardian signature (if under 18):