bodymind health

naturopathy • nutrition • herbal medicine • eating psychology coaching

# New Client Intake Form

Please help me to provide you with the most appropriate treatment possible by taking the time to complete this information questionnaire carefully and completely. Any information you provide will be treated with complete confidentiality as per the *Privacy Amendment (Private Sector) Act* 2000.

**bodymind health** collects personal information in order to assist the provision of its services. Personal information will not be collected unless it is relevant for a purpose directly related to a function or activity of **bodymind health**.

## New Client Information

Date: ______________

Title: ______________ Surname: ______________

Given Name: ______________ Preferred Name: ______________

Gender: ______________

Address: ______________________________

______________ Post Code: ______________

Phone (BH): ______________ Phone (AH): ______________

Phone (mobile): ______________ Email: ______________

Birth Date: ______________ Occupation: ______________

Emergency Contact: ______________ Phone: ______________

Family Doctor: ______________ Phone: ______________

Address: ______________________________

**Please bring with you copies of any recent blood test results to your appointment*

Referred by: ______________ (e.g. family, friend, web, Facebook)

Have you seen a Natural Health Practitioner before? (**Yes** / **No**) ______________

Clinic Type: ______________ Date(s): ______________

Do you have a Health Care/Pension/Student Card? (**Yes** / **No**) ______________

Card number: ______________ Expiry Date: ______________

Do you have any children? (**Yes** / **No**) ______________

Number of children: ______________ Ages of children: ______________

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**Issues and treatment:**

What are your main health issues concerning you?

Treatment to date?

What major health issues have you had in the past?

**Allergies (please use "X" to indicate):**

[ ] Dairy products
[ ] Soy products
[ ] Yeast
[ ] Wheat
[ ] Gluten
[ ] Starch
[ ] Sugars
[ ] Tomatoes
[ ] Artificial flavours
[ ] Colours
[ ] Alcohol
[ ] Metal jewellery
[ ] Band Aids
[ ] Cleaning Products
[ ] Cigarette smoke
[ ] Dust mites
[ ] Medicines
[ ] Grasses
[ ] Pollens
[ ] Fur
[ ] Other:

**Current medicines and supplements (Please include over-the-counter medicines)**

| Name of medicine | Dosage per day | Since when? | Reason for taking |
|---|---|---|---|
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**Family History (please list any significant medical conditions):**

| | | | |
|---|---|---|---|
| Mother: | | Father: | |
| Mother's Mother: | | Father's Father: | |
| Mother's Father: | | Father's Mother: | |
| Siblings: | | Other: | |

**Personal Medical History:**

Country and city of birth: ____

Pre-birth and birth (type of birth and any complications): ____

Infanthood (include any vaccination reactions): ____

Childhood: ____

Adolescence: ____

Adulthood: ____

Hospitalisation: ____

Experienced any traumatic events affecting health? ____

Never been well since: ____

Recently travelled overseas: ____

Do you have amalgam fillings? ____

Suffered from any head injuries in the past? (e.g. concussion, car accident) ____

Do you have any tattoos? Black only or colour? ____

What pets do you have? ____

What do you think is the weakest aspect about your health? ____

Current weight: ____

Are you happy with your current weight?

(If not, please specify why) ____

Height: ____

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## Informed Consent for Treatment

Obtaining an informed consent form is necessary to ensure that you are aware of the treatments being offered and that you are aware of possible side effects. Since each individual reacts differently to therapy, it is not possible to predict all risks and reactions.

By signing this informed consent form,

I _______________________________________________ understand that the treatments being provided to me or the person named below for whom I am legally responsible may include:

Herbal medicine, nutritional medicine, diet and nutritional counselling, lifestyle counselling, flower essence therapy, homeopathy and eating psychology coaching, and I hereby request and consent to the performance of the above treatments on me.

I also understand that there may be certain reactions to certain therapies and supplements, including herbal medicines and I understand that the instructions of using nutritional supplements, herbal medicines, homeopathic and flower essences medicines will be provided orally or in writing. I am aware that certain therapies may cause adverse reactions, including, but not limited to, allergic reactions to supplements, aggravation of symptoms or other side effects. I understand that certain nutritional supplements and herbs may be toxic in large doses and may be inappropriate to use during pregnancy. I will notify the person treating me if I am or become pregnant and will immediately notify them of any unanticipated or unpleasant effects associated with any treatments.

I do not expect the clinician to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinician to exercise judgement during the course of treatment which they think at the time, based upon the facts then known is in my best interest. I understand results are not guaranteed.

I am consenting to the treatments offered by Micaela Monteiro-Haig (BHSc-Naturopathy). I have been told about the risks and have had an opportunity to ask questions.

I am also aware that all information provided by myself remains strictly confidential and will only be revealed through written request by myself or where required by law.

I am also aware of the policy that because my appointment time is reserved exclusively for me, any cancellations to my appointment must be made before 5pm the previous day and before Saturday 12pm for Monday appointments otherwise a cancellation fee will apply (cancellation fee is set at half the price of booked consultation). 'No-shows' will be charged the full cost of the missed appointment. In some instances **bodymind health** reserves the right to charge a deposit/booking fee.

If I need to reschedule or cancel my appointment I will contact **bodymind health** on 0432 617 090 or **micaela@mybodymindhealth.com.au**.

**bodymind health** is a private naturopathic consultancy and fees are payable at the time of consultation.

I agree that this form holds valid for both present and future treatments for any future condition(s) for which I seek treatment.

| _Client Name_ | _Signature of Patient/Guardian_<br>_(to be signed in person at first consultation)_ | _Date_ |
|---|---|---|