GISBORNE HEALTH ESSENTIALS
Gisborne Health Essentials
43 Brantome Street, Gisborne, VIC, 3437

CLIENT DETAILS & HEALTH HISTORY

Please complete this form as much as possible to aid in your treatment. This is a private and confidential record of your information and will not be released except if you have provided us with written authorisation to do so.

Client Details					
First Name		Surname		DOB	
Address					
Home phone		Mobile			
Email		Occupation			
Emergency Contact Name		Contact number			
Your GP		Other healthcare practitioners			

How did you hear about us? If you were referred by a friend – who? We would love to thank them.

Communication	**Yes or No**
Do you give us permission to leave phone or text messages regarding your visits?	Yes
Do you give us permission to email you your treatment plan and correspond via email from time to time?	Yes
Would you like to receive health information, updates, and offers via email from time to time (no more than once per fortnight, because we don't like too many emails either!)?	Yes

Your health goals (in order of importance) How do you currently feel? How would you like to feel?	
1.	
2.	
3.	
4.	

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Current Medications / Supplements			
List all prescription medication, vitamins, minerals, herbal and homeopathic remedies you are currently taking.			
Brand & Name	Dose (how much & when)	Reason for taking	Date started taking

Allergies / Intolerances (medication, food, environmental, chemical)

Do you have any diagnosed medical conditions? Please list below

Are you pregnant (or could you be pregnant) or breastfeeding?	No

Declaration: I understand that whilst I am not obliged to provide any information, failure to provide full health details requested above or during consultations may compromise the quality of treatment provided.

Cancellation policy: Our practitioners at Gisborne Health Essentials are committed to providing all of their patients with exceptional care. In fairness to them and to allow the best appointment availability, we kindly ask that you inform us more than 24 hours before your appointment if you are unable to attend. A late cancellation fee of $25 will be implemented for cancellations within 24 hours or potentially the full fee if cancelled on the day of your appointment. Thank you for your understanding.

Client Signature:_____ Date:_____

If client under 18, signature of parent or guardian required (parent or guardian must attend clinic appointment)

Name Parent / Guardian:_____Signature:_____Date:_____