# BodyWorx Functional Therapies
# Client Health History Form

| **Client Information *(* indicates compulsory field)*** | | | | | | |
|---|---|---|---|---|---|---|
| Mr/Mrs/Ms/Miss | *Surname | | *Given Name/s | | | |
| Preferred Name | | | *Phone | | | |
| *Email address | | | | *Date of Birth | / / | |
| Address | | | | | | |
| Occupation | | | | | | |
| Medicare Card No. | | Expiry | | Position on card | | |
| Private Health? | Y/N | Name of Fund | | | | |

| **Emergency Contact Information** | | | | | |
|---|---|---|---|---|---|
| Name | | Relationship | | Phone | |
| | | | | | |

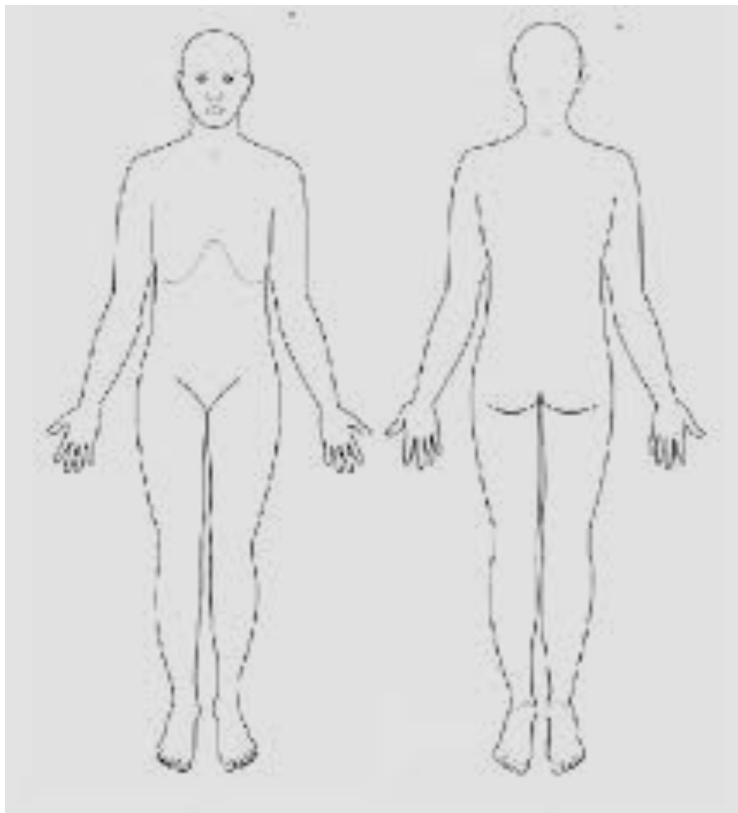
| **Referral Information** | |
|---|---|
| How did you find us? (circle) | Family/Friend   Social Media   Advertisement   Other (please specify) |
| | |

| **General Health Information** | **Are you a smoker? YES NO** |
|---|---|
| | |

PLEASE TICK ALL CONDITIONS THAT CURRENTLY APPLY TO YOU:

| **Pain/Stiffness** | | **Nervous System** | | **Skin** | | **Other** | |
|---|---|---|---|---|---|---|---|
| Neck/Jaw | | Pins & Needles | | Rashes | | Diabetes Mellitus | |
| Back | | Numbness | | Itching | | Cancer | |
| Shoulder/Arm/Hand | | Changes in vision | | Wounds slow to heal | | Hepatitis B/C | |
| Leg | | Muscle cramps | | Hives | | HIV/AIDS | |
| At night | | Muscle weakness | | Bruise easily | | ADHD/Autism | |
| In morning | | Body fatigue | | Dermatitis | | **Women Only** | |
| **Respiratory System** | | Confusion | | Psoriasis | | Difficult periods | |
| Difficulty breathing | | **Heart & Circulatory** | | Eczema | | Breastfeeding | |
| Cough | | Chest pain | | **Senses** | | Menopause | |
| Sinus problems | | Heart problems/Angina | | Headache/Migrane | | Pregnancy | |
| Hayfever | | Pace maker | | Dizzy/Light headed | | **Men Only** | |
| Asthma | | High blood pressure | | Heavy Headed | | Prostate problems | |
| **Balance** | | Low blood pressure | | Fainting | | Testicular pain | |
| Clumsiness/weakness | | Varicose Veins | | Light sensitivity | | **General wellbeing** | |
| Loss of balance | | Blood Clots/DVT | | Blurred vision | | Fatigue | |
| Vertigo | | Stroke | | Tinnitus | | Tension | |
| Legs/feet | | Cold extremities (hands/feet) | | Loss of hearing | | Brain fog | |
| **Other (add if not listed)** | | Swelling of extremities (hands/feet) | | Speech impairment | | Stress | |
| MS | | | | | | Irritability | |
| Glandular Fever | | | | | | Nervousness | |
| Allergies (list on next page) | | | | | | Sleep problems | |
| | | | | | | Loss of smell/taste | |

| | |
|---|---|
| Do you have any known Allergies? If so, please give brief description of what happens upon contact/ingestion: | |
| | |
| | |
| | |
| Any previous fractures and/or surgeries?<br>Please list fractures and approximate dates.<br>(Include car accidents/motor vehicle trauma). | |
| | |
| | |
| | |
| Do you have sensitivities to certain medications? If so please list: | |
| | |
| | |
| List of current medications/supplements/herbal remedies | |
| | |
| | |
| | |
| | |



Main area/s of concern today:______________________________

____________________________________

How long have you had this issue?
____________________________________

Have you had any other treatment?
____________________________________

____________________________________

Have you had this issue in the past?

____________________________________

Rate your pain on the pain scale –
1 = very low, 10 = excruciating (please circle)

1 2 3 4 5 6 7 8 9 10

*Any information you provide will be treated with complete confidentiality as per the Privacy Act 1988. Personal information will not be collected unless it is relevant and only collected by lawful means as per our Privacy Policy, available on request.*
*I understand that my health records are confidential and will be used for consultation purposes only. Under no circumstances will my file leave the BodyWorx Functional Therapies clinic or be discussed with anyone outside of the clinic without my prior written authority.*

Signature_______________________________________ Date_______________________

Name (Print)_____________________________________