**Health Practitioner** *** AL PM Co**
**Dr Stephen Phillips Eastern Medicine**

**Penrith Practice :**
252 High Street, Penrith NSW 2750
Mobile: 0414 339 300

**Katoomba Practice:**
157 Lurline Street, Katoomba NSW 2780

**Please bring this completed form to your first visit.**

**THE FOLLOWING INFORMATION IS STRICTLY CONFIDENTIAL AND IS NOT TO BE RELEASED WITHOUT PATIENT'S AUTHORITY**

In order to better serve you, we have provided you with the opportunity to complete the required patient information forms prior to your first appointment. Complete the detailed form as best you can. If in doubt, place a question mark in the space provided. Please do your best to provide us with as much information as you can, this will allow us to better treat you.

Your Name:_____First Appointment Date:_____

Date of Birth:_____Occupation_____Marital Status_____

Address:_____
(street, apartment number)

_____
(city, town) (state) (postcode)

Telephone number:(residence)_____(work)_____

Mobile:_____E-mail:_____
(only to be used by this practice)

In Case of Emergency, who should we contact?_____Mobile:_____

How did you come to attend this Clinic? Personally referral by_____

Referred by Employer:_____or Yellow Pages □ Sign □ Flyer □ Magazine □ Other □

Your Family Physician:_____Phone:_____

Physicians Address:_____Comments:_____

Other Primary Care Givers:_____

Other Doctors of Chinese Medicine consulted:_____

Do you have a Health Insurance? Yes / No (If yes, give name of fund)_____

Status: **Private** □ Pensioner □ **Veterans Affairs** □ **Motor Vehicle** □ **Workers Compensation** □

If an accident claim, please give Case Managers Name _____Phone:_____

Insurance Claim Number:_____Comments:_____

What is your level of insurance cover called:_____Can you claim any of the following?

**Acupuncture** □ **Herbal Consultation** □ **Herbal Medicine** □ **Chinese Herbal Medicine** □ **Massage** □

This clinic sets out to provide a practice, which is relaxing, educating and ultimately personally tailored. In order to do this, we must allocate and limit the number appointments weekly to ensure the best possible care for all. Under these conditions, **the clinic reserves the right to charge a cancellation fee, of fifty dollars ($50 max) for any appointment cancelled with less than twenty-four (24) hours notice, or a fee (of $50 per ½ hour booked), for all missed appointments.**

**I _____acknowledge that I am personally responsible for the payment of all accounts.**

**Signed _____Witness_____**

## Primary Health Concern

| |
|---|
| What is your primary health concern ? |
| How long have you had this condition? |
| What is your medical diagnosis ? |
| What is the name of the Physician who made the diagnosis? |
| When was this diagnosis made? |
| What specialists have you seen?<br><br>How has this condition been treated until now? |

Are there other areas you would like to see change in your general health? List all other health concerns in order of importance to you. If possible, please indicate the approximate month and year each health concern started. You can list any specific health, fitness or athletic goals you would like to discuss or to be assisted in attaining.

| | Health Concerns / Goals | Month / Year | Present Treatment / Comments |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |

How long has it been since you experienced excellent health?_____

Please give a detailed history of you primary health concern from when you were first aware there was a health problem through to the present. Include pertinent dates.

## Illness History

Can you see any conections with your present illness or any illnesses you have with any particular, accident, illness, incident, mental upset or unusual stress in your life? If yes, please explain.

Every disease, serious illness, accident, physical or emotional trauma or drug leaves can guide us to better know your bodies strengths and weaknesses. This will allow your health practitioner to better manage your health.

In the lists below, please circle all the major illnesses you have experienced in your life and indicate next to them the approximate age you were at the time.

| GENERAL | RESPIRATORY | CARDIOVASCULAR | SKIN |
|---|---|---|---|
| . allergies<br>. convulsions<br>. dizziness<br>. fatigue<br>. headaches<br>. migraines<br>. fibromyalgia<br>. CFS (chronic fatigue) | . chronic cough<br>. shortness of breath<br>. bronchitis<br>. asthma<br>. emphysema | . high/low blood pressure<br>. chronic congestive heart failure<br>. heart/disease<br>. Blot clots<br>. stroke/CVA<br>. pacemaker fitted | . rashes<br>. sensitive skin<br>. eczema<br>. bruise easily<br>. varicose veins<br>. psoriasis |
| **HEAD/NECK** | **WOMEN** | **MEN** | **COMMUNICABLE DISEASES** |
| . ear problems<br>. vertigo<br>. blurred vision<br>. earaches<br>. vision loss<br>. sinus | . menstrual problems<br>. menopausal problems<br>. infertility<br>. | . prostate cancer<br>. testicular cancer<br>. impotence<br>. infertility | . TB<br>. hepatitis<br>. HIV<br>. Herpes |

| Other conditions | | | |
|---|---|---|---|
| • Cancer | • Epilepsy | • Artificial Joints | • Osteoporosis |
| • Arthritis OA | • Bleeding disorders | • Internal Pins Wires | • Hair Loss |
| • Arthritis RA | • Diabetes | • Degenerated Discs | • Thyroid |
| • ADD | • Depression | • Irritable bowel syndrome | • Bone spurs |
| • Peptic Ulcer | • Gall Bladder disorder | • Ruptured ear drum | • Cataracts |
| **Please write any other illnesses you have experienced in the spaces below** | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Previous or Current Muscle Pain & Tension | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Neck** | | **Shoulders** | | **Arm** | | **Leg** | | **Back** | |
| Right | Left | Right | Left | Right | Left | Right | Left | Right | Left |
| Front | Back | Front | Back | Front | Back | Front | Back | Front | Back |

## Surgery Accident & Trauma

Please list any Surgeries, accidents and or traumatic events including those both did not and did require treatment.

Also please note any compilations that were as a result of surgery, medications or anaesthesia.

| Disease, Surgery, Accident | Age | Duration | Complete recovery? | Treatment (including medication) |
|---|---|---|---|---|
| | | | | |
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**Eyes.Ears.Nose.Throat:**

Have you experienced any of the following recently (tick or circle).

| | | | |
|---|---|---|---|
| Dizziness | Eye Strain | Spots in Eyes | Poor Vision |
| Worn Glasses | Night Blindness | Eye Pain | Cataracts |
| Blurry Vision | Ear Aches | Colour Blindness | Poor Hearing |
| Nose Bleeds | Sinus Problems | Ringing in Ears | Dry Throat |
| Dry Mouth | Copious Saliva | Mucus | Jaw Clicks |
| Grinding Teeth | Facial Pain | Teeth Problems | Mouth Ulcers |
| Sores on lips or tongue | Gum Problems | Recurrent sore throats | Laryngitis |
| Any comments: | | | |

Do you have any comments or questions about your health that you wish to be covered in this session?

Q1 _____

_____

_____

_____

_____

_____

_____

_____

## Medications & Immunisations

List all **Prescription drugs** that you are **currently** taking. Indicate present dose and how long you have been taking each medication.

| **Medication** | **Dosage** | **For how long** |
|---|---|---|
| | | |
| | | |
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| | | |

List all Prescription drugs that you **have taken in your life for periods *longer than six months*.** Indicate present dose and how long you took each medication.

| **Medication** | **Dosage (if you recall)** | **For how long** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please comment on any adverse side effects or reactions to any medications._____

_____

How many times have you been prescribed antibiotics over the last 10 years?_____

Have you ever been prescribed antibiotics for an extended period of time? Please explain when, why and for how long_____

_____

Do you use probiotics ("friendly" microflora) following antibiotic use? Y / N

**Please indicate your immunizations record**:

| Type | Anthrax | Cholera | DTP | HAV | HB | Hib |
|---|---|---|---|---|---|---|
| How many times | | | | | | |

| Type | Influenza | Measles | MMR | Meningococcal | Mumps | Pertussis |
|---|---|---|---|---|---|---|
| How many times | | | | | | |

| Type | Pneumococcal | Polio | Rubella | Tetanus | Typhoid | Varicella |
|---|---|---|---|---|---|---|
| How many times | | | | | | |

Tetanus-Diphtheria (Td) booster within last 10 years? ___/____
(Mo Yr)

Other_____Was there any serious reaction to any of the above vaccinations?

(Please give details)_____

**Food Supplements:**

List all of the food supplements you are currently taking. Indicate dosage taken in one day (i.e. if you take two tablets of Vitamin C 500mg/day, total daily is 1000mg).

| Type | Dosage | Total per day |
|---|---|---|
| | | |
| | | |
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**Herbal Medications:**

List all of the Herbal medications you are **currently** taking.
Indicate dosage taken in one day.

| Herb | Mg | Total per day |
|---|---|---|
| | | |
| | | |
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| | | |

Known ALLERGIES / Intolerances:_____

Known Environmental Allergies / Sensitivities:_____

**Neuropsychological:**

Have you experienced any of the following (tick or circle).

| | | | |
|---|---|---|---|
| Seizures | Areas of Numbness | Victim of Rape | Loss of Memory |
| Tingling Pins & Needles | Blackouts | Victim of Assault | Easily Stressed |
| Depression | Anxiety | Bad Temper | Attempted Suicide |
| Treated for Depression | Addiction Withdrawal | Easily Angered | Considered Suicide |
| Collapses | Poor Memory | Concussion | Other |

## Family History

What is your position in the family? (Oldest, Middle, Youngest etc.)_____

Briefly describe your relationship with your parents, as a child_____

_____As an adult_____

_____

How would you describe the health of your spouse?_____

Spouses
weight?_____Energy?_____Emotionally?_____

Other _____

Number of children living and any deceased? Living _____Deceased_____

If any deaths, please state cause of death._____

**Family History: ("L" for Living "D" for Deceased. Age is present age or age at time of death.**

| Relationship | L / D | Age | Diseases suffered / Cause of Death |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Maternal Grand Father | | | |
| Maternal Grand Mother | | | |
| Paternal Grand Father | | | |
| Paternal Grand Mother | | | |

If you think the following is also of significance. (eg two aunts died of breast cancer)

| Relationship | L / D | Age | Diseases suffered / Cause of Death |
|---|---|---|---|
| Maternal Uncles | | | |
| Maternal Aunts | | | |
| Paternal Uncles | | | |
| Paternal Aunts | | | |
| Brother / Sister (1) | | | |
| Brother / Sister (2) | | | |
| Brother / Sister (3) | | | |
| Brother / Sister (4) | | | |
| Brother / Sister (5) | | | |
| Brother / Sister (6) | | | |

**Personal Information:**

Your Age:_____Sex_____Marital Status_____Height_____

Present Weight_____Ideal Weight_____Do you diet?_____

If your present weight is different to your desired weight, have you ever been that weight.

If yes, how long has it been since you were that weight?_____

Name of Spouse (if applicable):_____Spouses Occupation:_____

How long have you been married?_____is this your first marriage? Yes _____No_____

If you married before, how many times (including this marriage) have you been married?_____

Number of Children? _____Your occupation (Nature of Work)_____

Do you enjoy your work_____Average Hours worked in a week?_____

## Personal Habits & Lifestyle Page 1

Average Time of Starting work_____ Average Time you get home from work_____

Education Background:_____

What hobbies do you have?_____

Please indicate your **general diet.**

Non Vegetarian:_____Vegetarian:_____Vegan:_____How long:_____

Other:_____

(Eastern Medicine does not advocate one diet for all people, rather each person must develop one that suits their condition.)

What did you have for Breakfast yesterday? (Time__)_____

| Breakfast | Time Eaten | |
|---|---|---|
| Morning Tea | | |
| Lunch | | |
| Afternoon Tea | | |
| Evening Meal | | |
| Snack | | |

Is this a usual daily food intake, both in amount, frequency and time of eating? Y / N

Comments_____

What is the source of your drinking water?

Tap(city)_____ Bottled (spring)_____Filtered_____Distilled_____ Well or Tank_____

If filtered what size water filter do you use? _____(how many micron)Brand?_____

How many cups / glasses do you drink in an average day? (Please give breakdown below)

| Coffee | Tea | Herbal Tea | Fruit Juice | Veg Juice |
|---|---|---|---|---|
| Water | Soft Drink Diet | Soft Drink | Coke | |
| Full cream Milk | Other | Low Fat | Soy Milk | Goat |
| Beer | White Wine | Red Wine | Spirits | Other |

Do you Smoke tobacco Y / N Have you ever smoked in the past Y / N If yes, for how long _____

If yes, please indicate what products you use and how often you use them?

_____

Does anyone in your household smoke? Y / N In the home? Y / N In the car? Y / N

Have you ever used non-prescription drugs? Yes / No (Confidential, if you prefer and not have this information recorded please tell your health practitioner at your consultation.
What types of Drug were they?_____

How frequent?_____

Do you regularly use (please circle) Laxatives, Sleeping Pills, Antacids, Pain Killers.

If so, please indicate types, frequency and amount:_____

_____

**Personal Habits & Lifestyle Page 2**

Have you ever had a problem with an addiction? Y / N

Food_____Alcohol_____Drugs_____Other_____

How many hours on average do you sleep per night More than 4 5 6 7 8 9 10 11 12

Is it hard to get to sleep Y / N Do you sleep lightly ? Y / N Do you wake from dreams ? Y / N

Do you have any recurring dreams ? ……..Is your sleep pattern normal at present Y / N

Do you feel refreshed when you wake in the morning _____Is it hard to get up _____

Do you like to exercise during a normal working week Y / N What about when on holidays ? Y / N

If you exercise regularly, what do you do (please specify frequency, intensity and duration)

_____

_____

_____

What do you do for recreation? _____

When was your last holiday? _____

How would you describe your present level of personal stress? (tick or circle)

| | | | |
|---|---|---|---|
| Minimal | Average | Considerable | Unbearable |

What is the main stress in your life? (tick or circle)

| | | | |
|---|---|---|---|
| Job Related | Financial | Marriage | Health |
| Family Members | Expectations | Interpersonal | Spiritual |

Comments_____

**Food Cravings / Desires / Aversions:**

Please indicate in the following boxes areas of "Like" "Dislike" or if the food makes you feel unwell.

You **can put more than one tick to emphasise** areas that you strongly like or dislike.

| Food / Flavour | Like | Dislike | Not for me | Food / Flavour | Like | Dislike | Not for me |
|---|---|---|---|---|---|---|---|
| **Pungent** | | | | **Bitter** | | | |
| Garlic | | | | Turnips | | | |
| Cloves | | | | Coffee | | | |
| Ginger | | | | Asparagus | | | |
| Chilli | | | | Radish | | | |
| Pepper | | | | Alfalfa | | | |
| **Salty** | | | | **Sweet** | | | |
| Seaweeds | | | | Sweet Potato | | | |
| Soy Products | | | | Dates | | | |
| Salty Pickles | | | | Peas | | | |
| Gomasio | | | | Carrots | | | |
| Miso soup | | | | Peaches | | | |
| **Sour** | | | | **Cucumber** | | | |
| Vinegar | | | | Oysters | | | |
| Sour Pickles | | | | Egg Plant | | | |
| Lemons | | | | Capsicum | | | |

**Women's Health Questionnaire**

**Women's Health: Px Name:** **Date:**

**(Practitioners Notes area):**

Age of first Menstruation? _____ Any difficulties with your period at that time?_____

Are you still menstruating? Y / N If No give reason, menopause or _____

Please give date of last Mense?_____Comments_____

Are you taking the pill or HRT, please specify _____

Are you menses' regular Y / N (eg every 28 days)_____for (eg 4-5 days)_____

Comment on cycle if necessary_____

Were they always like this, did anything change for you? (eg going on the pill)_____

Please describe the flow_____Clots?_____Colour?_____

Do you experience P.M.S? Y / N If so please describe the symptoms_____

_____

Are you sexually active Y / N

Is your Sex drive Non Existent ___Low___Medium___High ___Very High____

What kind of birth control do you use?_____

What kind of birth control have you used in the past?_____

When was your last PAP ?_____How often do you have them?_____

Have you ever had a sexually transmitted disease?_____

Number of pregnancies?_____Births?_____Miscarriages?_____Abortions?_____

Premature Births_____Other_____

Comments about birth experience/s (e.g. length of labour, caesarean e.t.c)_____

_____

How many times have you received an epidural?_____Other pain relief?_____

Have you every experienced breasts lumps?_____

Have you had uterine fibroids?_____

Do you have any vaginal discharge? Colour_____Any odor_____ Consistency_____

Do you have recurring vaginal infections? Never_____Rarely_____Frequently_____

Virginal Discharge?_____Colour_____Smell_____Other_____

Do you experience recurring bladder infections? Never_____Rarely_____Frequently_____

## Men's Health Questionnaire

**Men's Health: Px Name:** **Date:**

**(Practitioners Notes area):**

Are you sexually active Y / N

Is your Sex drive Non Existent ___Low___Medium___High ___Very High____

What kind of birth control do you use?_____

What kind of birth control have you used in the past?_____

Do you experience recurring bladder infections? Never_____Rarely_____Frequently_____