PATIENT CONSENT FORM

***Mandatory field**

TITLE: MR / MRS / MS / MISS / MASTER/DR

***FIRST NAME**: .... ***LAST NAME**: ....

***DOB**: ..../.........../...........

***ADDRESS**: ....

SUBURB: .... STATE: ....POSTCODE: ....

PHONE (H): .... ***MOBILE**: ....

***EMAIL**: ....

EMERGENCY CONTACT NAME: ....

RELATIONSHIP: .... CONTACT NUMBER: ....

HEALTH CARE DETAILS

DOCTOR'S NAME .... MEDICAL CENTRE: ....

PRIVATE HEALTHFUND: ☐ YES ☐ NO FUND NAME: .... POSITION ON CARD: ......

DO YOU HAVE A PENSION OR CONCESSION CARD? ☐ YES ☐ NO

EMPLOYMENT DETAILS

OCCUPATION: .... EMPLOYER: ....

EMPLOYMENT TYPE (Please tick):

☐ FULL TIME ☐ PART TIME ☐ CASUAL ☐ NOT WORKING

☐ OTHER: ....

REFERRAL SOURCE

***HOW DID YOU HEAR ABOUT OUR CLINIC? (Please Tick)**

☐ FAMILY/FRIEND: .... ☐ WEBSITE ☐ GOOGLE ☐ FACEBOOK

☐ DOCTOR ☐ SPECIALIST/SURGEON: ....

☐ SPORTS CLUB: .... ☐ OTHER: ....

LIFESTYLE

☐ COFFEE: ____ cups per day ☐ TEA: ____ cups per day

☐ WATER: ____ cups per day ☐ ALCOHOL: ____ cups per day

☐ SMOKE ☐ TAKE RECREATIONAL DRUGS

GENERAL HEALTH

DO YOU **CURRENTLY** HAVE OR HAVE YOU **PREVIOUSLY** HAD ANY OF THE FOLLOWING:

☐	PACEMAKER	☐	RHEUMATOID ARTHRITIS	☐	OSTEOARTHRITIS
☐	AUTOIMMUNE DISEASES	☐	DIABETES	☐	HIGH BLOOD PRESSURE
☐	LOW BLOOD PRESSURE	☐	STROKE	☐	EPILESPY
☐	BLOOD BORNE DISEASE	☐	CANCER		

☐ ALLERGIES (Please Specify): ……..

☐ HEART CONDITION (Please Specify): ……………………………………………………………………………………………………….

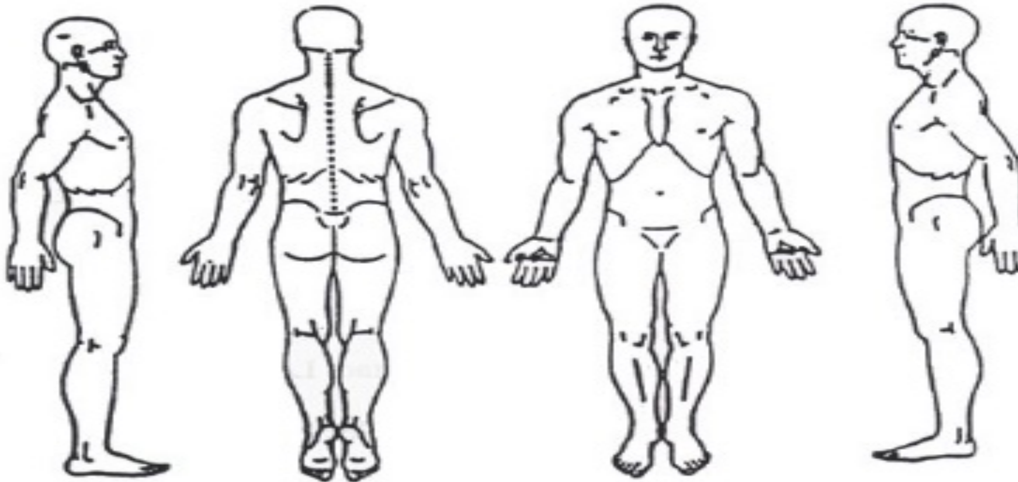
☐ OTHER MEDICAL CONDITION(s): ………..

MEDICATION

DO YOU TAKE PRESCRIPTION MEDICATION? Please list (e.g. Steroids, anticoagulants, statins, NSAIDs)
………
………
………

INJURY DETAILS

***BODY CHART:** **PLEASE INDICATE WHERE AND WHAT YOUR SYMPTOMS ARE (aching, tingling, shooting pain, etc).**



Cancellation Policy:

As we strive to provide a quality service for you, we use a pre-booking system. Therefore, we have a **24-hour cancellation policy.** Late cancellations or non-attendances will attract a fee if deemed unreasonable.

Additional Information:

- I give permission for Optimum Health and Performance to contact me with relevant reminders via text message or telephone
- I give permission to Optimum Health and Performance to keep me informed of relevant updates within our practice via email

Please sign below to indicate you agree with and acknowledge these policies.

SIGNED: ……………………………………………………………………………………………… DATE: ……………………………………………..