Bodycare Clinic

Northshore Branch
306 East Coast Road
Forrest Hill
Northshore 0620
Ph) 09 410 4770

个人信息 Patient Information

名(First name): _____ 姓(Surname): _____

出生日期(Date of Birth): _____ 职业(Occupation): _____

性别(Sex): ☐ 男(Male) ☐ 女(Female)

住宅电话(Home number): _____ 公司电话(Work number): _____

地址(Address): _____

移动电话(Mobile): _____ 电子邮件(Email): _____

(预约前一天我们会发短信或电子邮件，请提供手机号码或电子邮件地址。)

健康信息 Health Information

你有曾经接受过脊椎矫正(Chiropractic), 理疗(Physiotherapy), 中医治疗(Acupuncture) 吗? **(是/否)**

因上面写的原因在别的诊所接受过治疗吗? (Recently visited other professionals) **(是/否)**

最近1年内你有申请过ACC吗? (ACC number within one year?) **(是/否)**

是什么原因今天来到我们诊所? (Reason of Visiting) _____

Note

个人健康史 Health History

你有患过严重疾病吗? (Disease or Sickness) **(是/否)**

你有过重大事故吗? (Trauma) **(是/否)**

你目前服用任何药物吗? (Medication or Herbal Medicine) **(是/否)**

你有曾经抽过烟吗? (Smoking) **(是/否)**

你有安装心脏起搏器吗? (Pacemaker) **(是/否)**

你有严重头痛吗? (Headache) **(是/否)**

Note

家属史 Family History

你的家属人员里有疾病的人吗? (Any family history of Disease?) **(是/否)**

Note

现病史 Current History

你目前有肌肉骨骼关节问题吗? (Musculoskeletal) **(是/否)**

你目前有心血管系统问题吗? (Cardiovascular) **(是/否)**

你目前有呼吸系统问题吗? (Respiratory) **(是/否)**

你目前有消化系统问题吗? (Gastrointestinal) **(是/否)**

你目前有泌尿生殖系统问题吗? (Genito-urinary) **(是/否)**

你目前有眼，耳，鼻，喉问题吗? (Eyes, Ears, Nose & Throat) **(是/否)**

你有上面以外的问题吗? (Other problem)

Note

Additional History

你曾经有下面的 疾病吗? 如果有请画圈 (Please circle followings) 。

- ☐ HIV艾滋病(AIDs)
- ☐ 糖尿病(Diabete)
- ☐ 中风(Stroke)
- ☐ 肿瘤(Cancer)
- ☐ 结核(Tuberculosis)
- ☐ 风湿病(Rheumatism)
- ☐ 心脏病(Heart Attack)
- ☐ 癫痫(Epilepsy)
- ☐ 骨折(Fracture)
- ☐ 高血压(HBP)
- ☐ B型肝炎(Hepatitis B)
- ☐ 甲状腺病(Thyroid Dz)

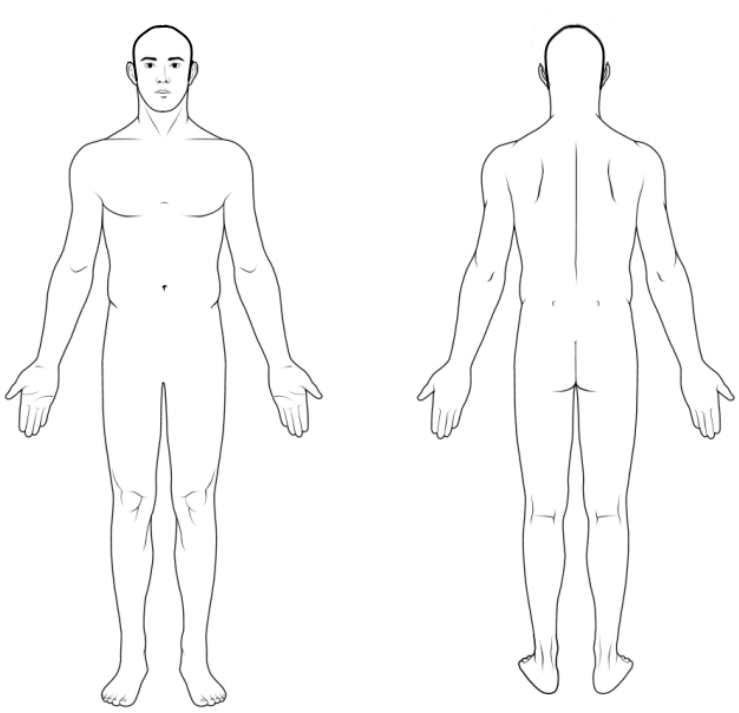
女性患者回答 Female Patient Only

你有可能怀孕吗? (Pregnancy) **(是/否)**
你处在更年期吗? (Menopause) **(是/否)**
你的月经周期规律吗? (Regular menstrual cycle) **(是/否)**
你有严重痛经吗? (Painful menstruation) **(是/否)**
你有上面以外的问题吗? (Other problem) **(是/否)**

Note

Body Chart

请用圈在下面的人体图上标记你不舒服的地方。



Patient Consent for Care By Bodycare Clinic and Share of Patient Information

Please circle one of the following: I am the **Patient** or **Parent** or **Guardian.**

- I consent the collection and passing of information between medical practitioner, specialists, health professionals, hospitals and insurance companies. That the information will be collected, held and used in terms of the Privacy Act 1993 and the Health information Privacy Code 1994.
- I have the right to see this information.
- Due to the nature of the treatment the practitioner may need to touch of palpate different areas on your body, this may help in the diagnosis or in location acupuncture points.
- You may be asked to remove certain items of clothing to enable better access to different parts of your body you can expect to have a towel or blanket to cover you.
- Some questions that you may be asked might seem irrelevant to you but they help the practitioners make a holistic diagnosis.
- If you feel uncomfortable in any way at any stage of the treatment for any reason please ask the practitioner as there may be some way to make you feel more comfortable. We will not cause offence and will make every effort to make you feel as comfortable as possible.
- You are welcome and encouraged to bring a support person with you while you have treatment.
- All procedures will be clearly explained prior to the time of treatment.
- Written consent from Guardian or Parent to be obtained before treating minors (16 years).
- I have the right to decline or withdrawal my consent to treatment at any time.
- If there is any issue with ACC45 registration and unable to claim the service, patient or client is fully responsible for the treatment charges.

I have read and understood the above information and certify that all the information that I have reported above is true to the best of my knowledge.

Patient's Signature: _____ **Date:** _____

Practitioner: _____

Practitioner's Signature: _____ **Date:** _____