Bodycare Clinic

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

환자 개인 정보 Patient Information

이름(First name): _____ 성(Surname): _____

생년월일(Date of Birth): _____ 직업(Occupation): _____

성별(Sex): ☐ 남자(Male) ☐ 여자(Female)

집 전화번호(Home number): _____ 직장 전화번호(Work number): _____

주소(Address): _____

핸드폰번호(Mobile): _____ 이메일 주소(Email): _____

(핸드폰번호나 이멜 주소를 주시면 진료예약 전날에 문자 메세지 나 이멜을 보내 드립니다. 꼭 기입 부탁 드립니다.)

건강 병력 Health Information

척추교정치료(Chiro), 물리치료(Physio), 한의 치료(Acu) 치료를 받은 적이 있으신가요? **(예 / 아니요)**

다른 클리닉에서 최근의 문제 때문에 치료를 받으신 적이 있으십니까? (Recently visited other professionals) **(예/아니요)**

ACC 등록을 최근 1년 안에 하신 적이 있으십니까? (ACC number registered within one year?) **(예/아니요)**

오늘 오신 이유는 무엇입니까? (Reason of Visiting) _____

Note

의료 건강 문제 Health History

현재나 과거에 심한 질병이나 건강 위험에 놓여진 적이 있으십니까? (Disease or Sickness) **(예/아니요)**

심각한 사고를 당한 적이 있으십니까? (Trauma) **(예/아니요)**

현재 어떤 양약이나 한약을 드시고 있으십니까? (Medication or Herbal Medicine) **(예/아니오)**

담배를 피우신 적이 있으십니까? (Smoking) **(예/아니오)**

맥박 조정기를 하시고 계십니까? (Pacemaker) **(예/아니오)**

두통이 심하십니까? (Headache) **(예/아니오)**

Note

가족 내력 Family History

혈연 가족 관계분들 중에 질병을 겪거나 현재 있으신 분 계신가요? (Any history of disease in family) **(예/아니요)**

Note

현재 문제 Current History

근육 골격 관절 문제가 있으십니까? (Musculoskeletal) **(예/아니오)**

심장혈관의 문제가 있으십니까? (Cardiovascular) **(예/아니오)**

호흡기관에 문제가 있으십니까? (Respiratory) **(예/아니오)**

위장기관에 문제가 있으십니까? (Gastrointestinal) **(예/아니오)**

비뇨생식기에 문제가 있으십니까? (Genito-urinary) **(예/아니오)**

눈, 코, 입, 귀, 목 부위에 문제가 있으십니까? (Head) **(예/아니오)**

위에 해당하지 않은 다른 문제점이 있으십니까? (Other problem) **(예/아니오)**

Note

추가적인 문제 Additional History

아래에 해당 사항이 있으시면 동그라미 해주세요.(Please circle)

- ☐ **에이즈(AIDs)**
- ☐ **당뇨(Diabete)**
- ☐ **뇌졸증(Stroke)**
- ☐ **암(Cancer)**
- ☐ **결핵(Tuberculosis)**
- ☐ **류마티즘(Rheumatism)**
- ☐ **갑상선(Hypo/Hyper Thyroidism)**
- ☐ **심장마비(Heart Attack)**
- ☐ **간질(Epilepsy)**
- ☐ **골절(Fracture)**
- ☐ **고혈압(HBP)**
- ☐ **B형 간염(Hepatitis B)**

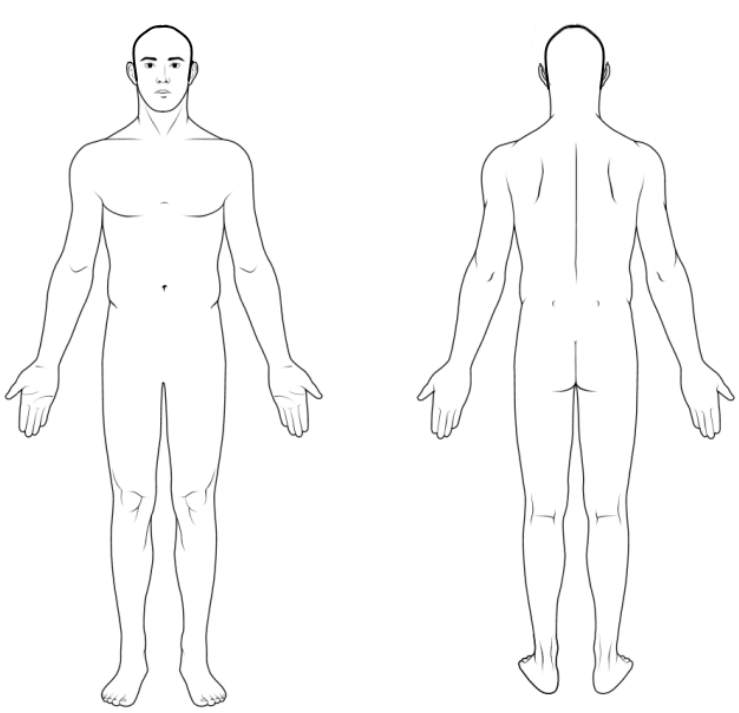
여성 전용 Female Patient Only

임신 가능성이 있으십니까? (Pregnancy) **(예/아니오)**
폐경 중에 있으십니까? (Menopause) **(예/아니오)**
심한 월경 통증이 있으십니까? (Painful period) **(예/아니오)**
월경주기가 규칙적입니까? (Regular Period) **(예/아니오)**
이 외에 다른 문제가 있으십니까? (Others) **(예/아니오)**

Note

신체 챠트 Body Chart

문제 있는 부위에 동그라미 표시 해주세요.



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:** _____