QUANTUM HEALING
CENTRE

PATIENT HISTORY / DETAILS

Private and Confidential

Please remember, no matter what you're current state of health, you can begin to appreciate yourself as a growing, changing person and allow yourself to move toward a happier life and positive health.

Date: _____ Primary Healthcare Practitioner: _____

PERSONAL DETAILS

First Name:	**Surname:**	**DOB:**	**Sex:** M / F
Phone:	**Mobile:**	**Email:**	
Address:			
Suburb:	**Postcode:**		
Marital Status: Single / Married / De-facto / Divorced / Widowed		**Partner's Name:**	
Number of Children: Name:	Age:	Name:	Age:
Name:	Age:	Name:	Age:
Are you Pregnant or suspect you are Pregnant: Y / N			
Employed: Y / N Part Time / Casual / Full Time		**Occupation:**	

HEALTH PRACTITIONERS

Doctor's Name:	**Location:**	**Phone:**

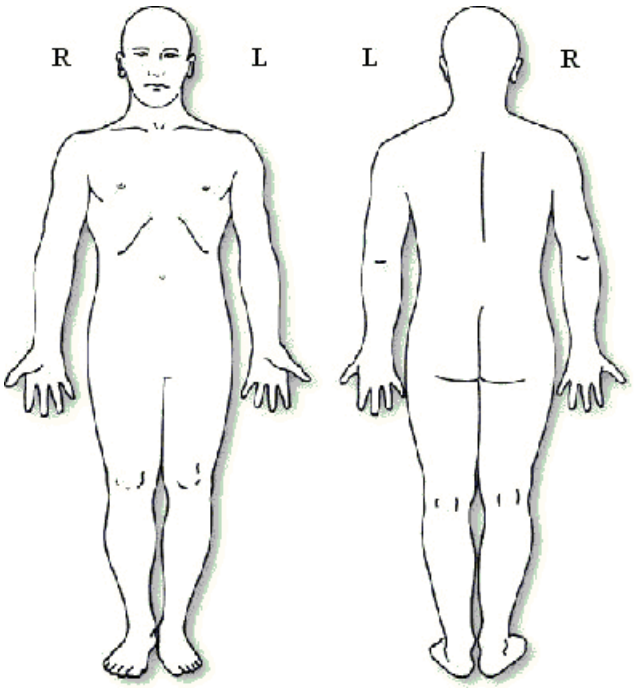
SYMPTOMS OF CONDITION

What is the main reason for your visit today:

Chief complaint: 1. Main:	How long?
2.	How long?
3.	How long?

PAIN DIAGRAM: Please circle areas of pain, numbness, tingling, and/or burning following diagram (2 body part limit):

Pain= P Numbness= N Tingling= T Burning=B



SEVERITY: How severe is your pain / Numbness / Burning? (Circle)

0	1 2 3	4 5 6 7	8 9 10
No Pain	Mild	Moderate	Severe

NATURE: Without pain-killer, pain is

❑ Occasional ❑ Continuous ❑ Intermittent
❑ Improving ❑ Worsening ❑ Unchanged ❑ Up and down
❑ Sharp ❑ Shooting ❑ Aching ❑ Dull

EFFECT ON DAILY LIFE: Does the condition

Wake you up at night? ❑ **Yes** ❑ **No**
Interfere with work activities? ❑ **Yes** ❑ **No**
Interfere with recreational activities? ❑ **Yes** ❑ **No**

What aggravates your pain or health problem?

❑ Activity ❑ Work ❑ Exercise ❑ _____

What makes your pain or health problem better?

❑ Rest ❑ Heat ❑ Ice ❑ _____

Do you have headaches? ❑ **Yes** ❑ **No** (Please tick type)

❑ Tension ❑ Throbbing ❑ Sinus ❑ Cervicogenic ❑ Migraine

Comments: _____

DETAILS OF THE CURRENT INJURY – PLEASE TICK

How did the injury/symptom soccur?

☐ Previous injury/recurrence ☐ Gradual onset ☐ Sudden/traumatic ☐ Lifting ☐ Bending ☐ Fall

☐ Twisting ☐ Whiplash ☐ Running ☐ Throwing ☐ Other _____

Where did the injury occur? ☐ Home ☐ Work ☐ Sports/Recreation ☐ School ☐ Vehicle (MVA) ☐ Other _____

Date of Injury: How long have you had these symptoms?

ANY SURGERY / OPERATIONS – PLEASE LIST

1.	2.
3.	4.
5.	6.

INJURIES FROM EMOTIONAL TRAUMA – PLEASE LIST

1.	2.
3.	4.
5.	6.

CHILDHOOD DISEASES - CROSS[X] / IMMUNISATION - TICK[√]

☐ Measles	☐ Chicken pox	☐ Polio	☐ Asthma	☐ Immunised
☐ German measles	☐ Pertussis	☐ Tetanus	☐ Eczema	☐ Complications
☐ Mumps	☐ Diphtheria	☐ Influenza	☐ Unsure	☐ Other _____

PAST – PRESENT MEDICAL CONCERNS TICK[√] IF IT'S *YOU* AND CIRCLE IF IT'S *YOUR FAMILY*

☐ Digestion	☐ Bowel	☐ Small Intestine	☐ Liver	☐ Gallbladder
☐ Kidneys	☐ Bladder	☐ Thyroid	☐ Adrenals	☐ Immune system
☐ Blood sugar	☐ Circulation	☐ Heart disease	☐ Blood pressure	☐ Reproductive
☐ Bone integrity	☐ Muscle problems	☐ Stress	☐ Anxiety	☐ Depression
☐ Insomnia	☐ Fatigue	☐ Weight issues	☐ Diabetes	☐ Arthritis
☐ Allergies	☐ Skin conditions	☐ Cholesterol	☐ Alcoholism	☐ HIV Aids
☐ Hepatitis A B C	☐ Sex trans. disease	☐ Hyperactivity	☐ Asthma	☐ Lung disorders
☐ Eye disorders	☐ Hearing disorders	☐ Sinus problems	☐ Cancer	☐ Genetic

☐ Other:

DIAGNOSTIC TESTS:	TREATMENT HISTORY:
Please check box and list date if you had any of the following tests performed for this problem:	Please check box and list date if you have tried any of the following treatments for this injury/symptoms:
☐ MRI	☐ Cortisone injection
☐ Xray	☐ Epidural injection
☐ CT Scan	☐ OTC pain medication
☐ Utrasound	☐ Surgery
☐ Myelogram	☐ Physical Therapy
☐ EMG	☐ Chiropractor
☐ Other	☐ Walker/crutch/wheelchair ☐ Brace

ALLERGIES – INTOLERANCES – PLEASE TICK & LIST

☐ Drugs	☐ Occupational
☐ Foods	☐ Herbs
☐ Animals	☐ Pollen
☐ Insects	☐ Plants
☐ Chemicals	☐ Others

RISK FACTORS – PLEASE TICK AND SPECIFY WHERE APPROPRIATE

☐ **Do you smoke tobacco** - How many per week ( )

☐ **Do you drink caffeinated beverages** - How much per week ( ) - Tea( ) Coffee( ) Cocoa( ) Cola( ) Other( )

☐ **Do you drink alcohol** - How much per week ( ) - Beer ( ) Spirits ( ) Wine ( ) Liqueurs ( ) Other( )

☐ **Blood Pressure - Hypertension**	☐ **Cholesterol**	☐ **Sugar** – how much ( )
☐ **Emotional and Mental stress**	☐ **Home stress**	☐ **Workplace stress**
☐ **Obesity**	☐ **Insomnia**	☐ **Sedentary lifestyle - unfit**

PLEASE TICK ANY OF THE FOLLOWING **YOU MAY HAVE HAD IN THE LAST 6 MONTHS**

☐ **Antacids**	☐ **Lithium**	☐ **Insulin**	☐ **Ulcer medicines**	☐ **Heart medicines**
☐ **Laxatives**	☐ **Radiation therapy**	☐ **Aspirin/Panadol**	☐ **Chemotherapy**	☐ **Sleeping pills**
☐ **Thyroid medicine**	☐ **Pill or HRT**	☐ **Antibiotics**	☐ **Antiinflam. med.**	☐ **Antidepressants**

CURRENT **MEDICATION PRESCRIPTION & NON-PRESCRIPTION** VITAMINS, MINERALS & HERBALS

Name	Dosage	Purpose

HOW WERE YOU REFERRED TO THIS CLINIC

☐ **Referral:** Name of Doctor / Person who referred you:

☐ **Facebook** ☐ **Instagram** ☐ **Other Social Medias** ☐ **Gym** ☐ **Magazines / Newspapers:**

☐ **Website:** ☐ **Brochures** ☐ **Event/ Presentations** ☐ **Passing by** ☐ **Other:**

WHAT TYPE OF CARE WOULD YOU LIKE

☐ **Symptomatic Care:** Symptomatic assessments and treatment of presenting symptoms

☐ **Corrective Care:** Symptomatic assessments and treatment of presenting symptoms.
Maintain symptomatic relief, whilst identifying underlying diet and lifestyle causative factors.
Tailored programs to correct, support and maintain your health and well-being

☐ **Wellness Care:** Composite of symptomatic and corrective care.
Integrating the comprehensive wellness program, which includes additional in-depth evaluations and tailored programs to optimise, enhance and maintain well-being