11 Principles Pty Ltd

Clinic: 18 Norseman Street, East Victoria Park, WA 6101 (08 9355 5331
Postal Address: PO Box 1232, East Victoria Park, WA 6981

CLIENT INFORMATION RECORD

Personal Details:

Family Name:		
First Name:		
Sex: ☐ Male ☐ Female	Age:	Date of Birth:

Street Address:		
Suburb:	State:	Post Code:
Home Phone:	Mobile:	
Email:		
Pension Card Number:		

Postal Address:		☐ **As Above**
Suburb:	State:	Post Code:

Person to contact in case of an **Emergency**:

Full Name:	Relation:	
Street Address:		☐ **As Above**
Suburb:	State:	Post Code:
Home Phone:	Work Phone:	
Mobile:		

If client is a minor (under 18 years old), please give **Parent/Guardian** information:

Full Name:	Relation:	
Home Phone:	Work Phone:	
Signature:		

Please detail how you found out about us:

☐ Referral by ? ..... ☐ Brochure (from where?) .....

☐ Website ☐ Newspaper ☐ Magazine ☐ Other .....

HEALTH AND WELL-BEING PRIORITIES

In your opinion, what are your most important concerns? What do you want to improve? What would you like to change in your life? What feels like it is out of balance? Consider the physical, mental, emotional, and spiritual aspects.

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

IMMUNISATIONS AND DISEASES

Indicate any '**childhood' diseases** you have had with a ☑ **TICK**.
Indicate any **immunisations** you received as a child or an adult with a ☒ **CROSS**.

☐ Triple Antigen	☐ Polio	☐ dTpa (Diptheria, Tetanus, Pertussis)
☐ Whooping cough	☐ Chicken Pox	☐ Hib (Haemophilus Influenza B virus)
☐ Measles	☐ German Measles	☐ MMR (Measles, Mumps and Rubella)
☐ Diphtheria	☐ Mumps	☐ Pneumococcal (PCV)
☐ Tetanus	☐ BCG (Tb)	☐ MCV4 (meningitis)
☐ Hepatitis A	☐ Hepatitis B	☐ Meningococcal C
☐ Tuberculosis	☐ Influenza	☐ Rotavirus
☐ Scarlet Fever	☐ Rheumatic Fever	
☐ Cholera	☐ Smallpox	☐ HPV (girls)
☐ Malaria	☐ Dengue Fever	☐ Rubella Vaccine (12yo girls)

ILLNESSES AND CONDITIONS

Please ☑ **TICK** any **present** illnesses or conditions.
Please place a ☒ **CROSS** next to any **past** illnesses or conditions.

Skin:

☐ Bruise Easily	☐ Eczema	☐ Psoriasis	☐ Acne
☐ Itching	☐ Rashes		

Musculoskeletal System:

☐ Neck Pain/Stiffness		☐ Upper Back Pain	
☐ Pain between Shoulder blades		☐ Low Back Pain/Stiffness	
☐ Hip Pain		☐ Knee Pain or Swelling – R or L	
☐ Pain/Tingling in Feet - R or L		☐ Chronic Sprains – R or L	
☐ Rheumatoid Arthritis		☐ Osteo- Arthritis	☐ Gout

☐ Joint Pain/Stiffness location(s) ……

Eyes, Ears, Nose & Throat:

☐ Dental Problems	☐ Dentures	☐ Vision Problems	☐ Ringing in Ears
☐ Sore Throat	☐ Frequent Colds	☐ Tonsillitis	☐ Herpes
☐ Sinus Problems	☐ Hayfever		

Nervous System:

☐ Loss of Sleep	☐ Nervousness	☐ Anxiety	☐ Panic Attacks
☐ Forgetfulness	☐ Brain Fog	☐ Depression	☐ Hyperactivity
☐ "Wired" feeling	☐ Alcoholism	☐ Drug Addiction	

Gastrointestinal:

☐ Poor Appetite	☐ Excessive Appetite	☐ Bad Breath	☐ Heartburn
☐ Stomach Cramps	☐ Gas /Wind	☐ Fatigue after Eating	☐ Bloating after Meals
☐ Constipation	☐ Diarrhoea	☐ Trouble Losing Weight	

Cardiovascular/Respiratory:

☐ Cold Hands/Feet	☐ Poor Circulation	☐ Chest Pain	☐ High Cholesterol
☐ Low Blood Pressure		☐ High Blood Pressure	
☐ Asthma	☐ Chronic Cough	☐ Other Lung Conditions ……..	

Endocrine/Hematology:

☐ Anemia ☐ Low Blood Sugar ☐ Diabetes Type I or Type II
☐ Thyroid Gland Trouble ☐ Sluggish Metabolism
☐ Hormone Problems ☐ Other …….

FAMILY HISTORY

Please indicate if any of your **blood relatives** have suffered from the following disorders or illnesses.

Cancer (indicate type if known), Diabetes (Type I or II?), Asthma, Heart Disease, Stoke, High Blood Pressure, High Cholesterol, Alcoholism, Drug Dependency, Mental Health Issues

Father (Living or Deceased?) **Age**	**Mother** (Living or Deceased?) **Age**

Brother or **S**ister	**Age**	**Medical Problems/Health Conditions**

SOCIAL HISTORY

Helps to determine how lifestyle affects your health and well-being.

Employment ..... Hours of work per Day/Week: .....

Activities done at work: .....

.....

Exercise Y N - describe type and frequency .....

.....

.....

Other **Leisure** Activities .....

What do you do for **relaxation**? .....

.....

Sleep – describe your sleep habits .....

.....

What causes **stress** in your life? .....

.....

What makes you **happy**? .....

.....

What sorts of things **worry** you? .....

.....

Do you have a **support** person/ someone you can discuss problems with? Y N

HOSPITALISATIONS AND ACCIDENTS

Please list any hospitalisations including any **surgeries and operations**.
Please list any other **incidents** including accidents (e.g. scars, sporting injuries).

..... Year .....
..... Year .....
..... Year .....
..... Year .....
..... Year .....
..... Year .....
..... Year .....

ALLERGIES AND INTOLERANCES

Please list any sensitivity to medicines, food, additives, chemicals, plants, animals and the signs and symptoms they cause e.g. bloating, itchy eyes, rash, anaphylaxis

....
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....

MEDICATIONS

Please list any **prescribed medications** and **over-the-counter medications** you currently take to be checked for compatibility and efficiency for your body.

Name of Item *e.g. Procid*	Purpose *for joint pain/gout*	Dosage and Frequency *500mg twice daily*
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.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

NATURAL REMEDIES

Please list any **natural remedies, supplements, herbs, vitamins and minerals** you take to be checked for compatibility and efficiency for your body.

Name and Strength *e.g. Fish Oil 1000mg*	Brand name (important) *Eco by Cenovis*	Dosage and Frequency *1 three times daily*
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.....	.....	.....
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.....	.....	.....
.....	.....	.....

Office Use:	Date:	Client File:	