The HerbClinic
PERSONALISED HEALTHCARE, NATURALLY

PATIENT REGISTRATION FORM

(PLEASE FILL IN ONLINE OR PRINT, FILL IN AND SCAN TO THE CONTACT DETAILS ON PAGE 4)

Today's date:	

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / De Facto / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ❑ M ❑ F
Street address:		Mobile Phone no:			Home phone no.:
P.O. box:	City:		State:		ZIP Code:
Occupation:	Email Address:				

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

EMERGENCY CONTACT

Name:	Birth date:	Address (if different):	Home phone no.:

Is this person a patient here? ❑ Yes ❑ No

Occupation:		Address:	Emergency contact no.:

Patient's relationship to contact: ❑ Parent ❑ Spouse ❑ Child ❑ Other

PRESENTING COMPLAINT

Please state your primary reason for attending our clinic. Please list the first time you noticed the condition and describe any factors that you suspect that played a role in its onset and perpetuation.

Has this been diagnosed? If yes – by who, and what was the diagnosis

Regarding your chief concern, have any treatment, diets or therapies brought you real improvement or relief?

Please list any other health concerns.
Please list all medication and/or supplements that you are currently taking; include dosage.
What would you like to achieve as a result of seeing a pratctitioner?

HEALTH HISTORY

What Vaccinations have you had?
Please list any significant illnesses that you have had in the past.
Have you ever been hospitilised?? Please indicate reason and year.
Any significant adult traumas, grief or stress (eg. Accidents, falls, emotional, relationship breakups, deaths, etc)?
Any significant childhood trauma, grief or stress?
Sleep – Time awake/asleep, broken?
Do you have any allergies? (food, environment, drug, etc)

LIFESTYLE
Sleep – Time awake/asleep, broken?
Exercise – Type & Frequency
Relaxation – Type & Frequency
General Stress – Causes (family/work) Please also rate stress levels from 1 (low) – 10 (high)
Relationships - Supportive – Intimate and friendships
Social Activities/ Hobbies
Energy – peaks/troughs, tiiming Please rate energy levels from 1- 10
Holidays – Frequency, history or travel
Spriritual/cultrual activies
Alcohol intake – type and frequency

Smoking – history and frequency
Recreational drug use – type, history and frequency
Environmental stress – EMF, chemicals, heavy metals, cosmetics
Exposure to animals – type of animal, frequency

FAMILY HISTORY

Please provide details of any illnesses that members of your family have experienced.

Maternal	Paternal	Siblings	Children

I declare this information to be up to date and true to the best of my knowledge. I give consent to the practitioner to perform a Naturopathic and/or Nutritional consultation based on the information provided in this form, and during the consultation. I understant treatment therapy with a Naturopath or Nutritionist frequently requires dietary and lifestyle changes and potentially nutritional and/or suppementation. As with other therapists, treatment recommendations come with risks including aggravation of health conditions and reaction to herbal and nuturitional supplements, however, the incidences of these reactions are vey uncommon. It is therefore important for you as the patient to fully discose all aspects of your health history and status covered in the form and during consultation. I understand that at any point I have the right to stop treatment, consult with another practicing professional or request a change to my treatment plan. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Herb Clinic or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

New Zealand Clinic Located at:

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Australian Clinic Located at:

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