AYURVEDAVILLAGE

Client Information

Client Details

Family Name:		**Given Name:**	
Date of Birth:		**Gender:**	
Street:		**Suburb:**	
State:		**Postcode:**	
Telephone:		**Mobile:**	
Email:			
Occupation:			
Employer Name:			

Emergency Contact

Contact Name:		**Relationship:**	
Address:		**Suburb:**	
State:		**Postcode:**	
Telephone:		**Mobile:**	
Email:			

This declaration must be filled out and signed prior to commencement of any treatment.

IS THIS TREATMENT RELATED TO AN ACCIDENT INSURANCE CLAIM OR WORKCOVER CLAIM? YES / NO (PLEASE CIRCLE)
If YES please provide insurance company details _____

_____

Client Declaration

I declare the information contained in this health declaration is, to the best of my knowledge to be, and believe true and accurate. I consent to this information together with any file notes to be shared with Aspects of Healing practitioners and staff, and if necessary, with other accredited medical practitioners.

Client Name: _____ Client Signature: _____

Date: ____ /____ / ____

Ayurveda Village
33 Sandow Rd Verdun SA 5254
Ph: 8110 4300

Do you have Private Health Insurance? ***(If yes, please detail below)***

Yes	**Name of Fund:**	**Membership No.**	
Will you be claiming services received at Aspects of Healing through your Private Health Fund? YES / NO Unsure			

Which Service or Practitioner are you seeking? ***(please tick more than one if required)***

Ayurvedic	**Reflexology**
Remedial / Massage	**Kinesiology**
Physiotherapy	**Homeopathy**
Bowen Therapy	**Counselling/Psychotherapy**
Dry Needling	**Reiki / Energetic Therapy**
Chinese Herbal Medicine	**Aromatherapy**
Acupuncture	**Australian Bush Flower Essence**
Cupping	**Other -**

Have you received this treatment or service before?

How did you hear about Aspects of Healing ***(please circle)***

Word of Mouth	**Internet Search of Treatment**	**Aspects of Healing Website**	**Advertisement**	**Other:**

Would you like to receive occasional news and promotional offers from Aspects of Healing or Ayurveda Village via email?

(*please circle)* **YES / NO**

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Client Information

Health Information – Do you suffer from or have you in the past suffered from any of the following?	**Detail Here**	
	YES	**NO**
Are you being treated by a Medical Professional for any Illness or Suspected Illness?		
Are you currently taking any Medications or Drugs? Please give details if taking any.		
Are you Pregnant?		
Do you have any known Allergies (including Latex)?		
Have you ever had, or been told you had, or received Advice or Treatment for:		
High Blood Pressure, Chest Pain, Stroke, High Cholesterol, Rheumatic Fever, Irregular Heart Rate or any Heart or Vascular Complaint?		
Asthma, Bronchitis, Tuberculosis, Pleurisy, Sore Throats or any other Lung complaint?		
Migraines, Headaches, Head Injuries / Concussion, Anxiety, Depression, or Stress Related conditions?		
Arthritis, Rheumatism, Gout, Tendonitis, Repetitive Strain Injury, Problems with Bone, Osteoarthritis, Strains, Strained Back, Sciatica, Whiplash, Spondylitis Sprains, Joints or Muscles?		
Indigestion, Ulcer, Hiatus, Reflux, Hernia, Bowel Disorder?		
Hepatitis, Hepatitis C, Cirrhosis or any Liver or Gall Bladder Disease?		
Endocrine, Gland, Hyperthyroidism or Hormonal Problems, Diabetes, Insulin, Oral Hypoglycaemics, Diet?		
Cancer, Tumour, or Malignancy?		
Neurological or Nervous Disorders such as Epilepsy, Seizures, Stroke, Transient Ischemic Attacks, Hemiplegia, Paralysis?		
Psoriasis, Eczema, Dermatitis, or any Other Skin Related Condition?		
Any Chronic Disease or Infection eg: HIV, Malaria, Tropical Infection?		

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Blood Disorders or Conditions, Haemophilia, DVT, PE, Warfarin?		
Hearing Problems, Vision Problems, Blindness, Cataracts, Conjunctivitis		
Currently Undergoing Chemotherapy, Radiotherapy, Immunotherapy?		
Creutzfeldt – Jakob, Parkinson's, Alzheimer's, Dementia		
Surgery, Surgical History – What and When?		
Any Health Problems / Medical Condition not mentioned above?		
Do you contemplate seeking Medical Advice, Investigation or Treatment for any Current Health Problem(s)?		

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CONFIDENTIAL DOCUMENT

Thank you for completing this form.

Please Provide Details:

Are you currently receiving care / support or treatment from any Health Professionals?
If Yes, please list:

- ❖
- ❖
- ❖

Your Family Doctor:

Name of Doctor
Address of Surgery

Telephone (if possible)

Consent to release personal medical information.

I give permission for a medical report to be obtained from my family doctor and other health professionals if necessary.

YES NO

Signature_____ Date _____

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