Max Health
THERAPIES

89 Manning Road, Manning WA 6152
p: (08) 9450 3221
e. maxhealth@maxhealth.com.au
www.maxhealth.com.au

CLIENT DETAILS

FIRST NAME:_____SURNAME:_____

ADDRESS:_____P/CODE_____

PHONE-HM:_____ WORK:_____

MOBILE:_____ FAX:_____

EMAIL:_____ MARTIAL STATUS SINGLE MARRIED

D.O.B_____ OCCUPATION/S:_____

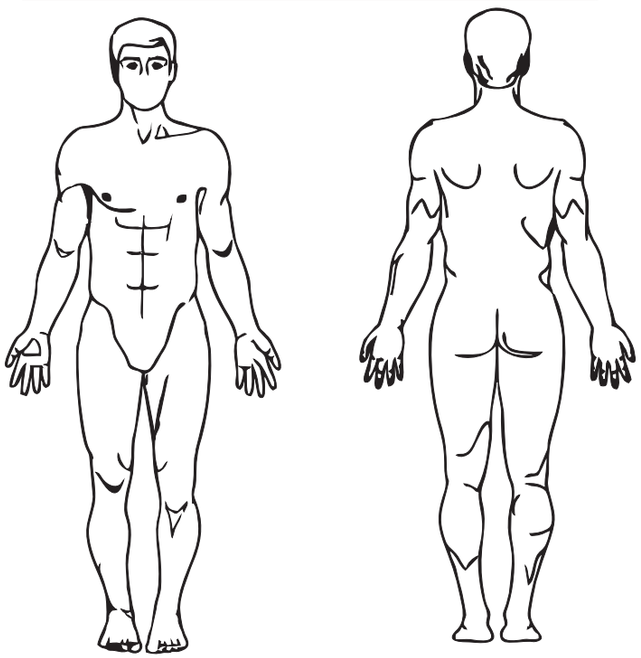
WHO RECOMMENDED YOU TO QIMAX?:_____

PLEASE NOTE: FEES ARE PAYABLE ON THE DAY OF SERVICE HEALTH COVER YES NO

HEALTH HISTORY

PLEASE CIRCLE AREAS OF MAIN CONCERN
AND DESCRIBE YOUR SYMPTOMS

_____
_____
_____
_____
_____
_____
_____



WHEN AND HOW DID YOUR SYMPTOMS BEGIN

_____
_____
_____
_____
_____

GRADE YOUR SYMPTOMS (IF ANY) ON A SCALE OF 1 TO 10

0----------5----------10
NIL MODERATE SEVERE

DO YOU FELL YO ARE

IMPROVING DETERIORATING STATIC

HAVE YOU CONSULTED ANY OTHER HEALTH PROFESSIONALS
REGARDING YOUR CONDITION IN THE PAST FIVE YEARS

1. NAME:_____

REASON:_____

CONDITION:_____

2.NAME:_____

REASON:_____

CONDITION:_____

3.NAME:_____

REASON:_____

CONDITION:_____

4.NAME:_____

REASON:_____

CONDITION:_____

LIST RECENT X-RAYS AND SPECIAL TESTS.

_____
_____
_____
_____

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HEALTH HISTORY

DO YOU HAVE ANY KNOWN ALLERGIES? YES NO
DETAILS:

DO YOU BRUISE EASILY OR HAVE A BLEEDING DISORDER?
YES NO DETAILS:

HAVE YOU HAD ANY MAJOR DISEASE, INCLUDING THOSE IN CHILDHOOD: YES NO

PLEASE LIST:_____

_____

_____

_____

_____

LIST SIGNIFICANT FALLS , **ACCIDENTS OR SURGERY**

_____

_____

_____

_____

IS THERE A FAMILY OR SELF HISTORY OF

- ☐ IMMUNE DEFICIENCY
- ☐ CANCER
- ☐ OSTEOPOROSIS
- ☐ EATING DISORDERS
- ☐ OBESITY
- ☐ HEART DISEASE
- ☐ DIABETES
- ☐ STROKE

LIST ANY MEDICATIONS AND/OR VITAMINS YOU ARE TAKING (PRESCRIPTION AND NON-PRESCRIPION)

_____

_____

_____

_____

_____

_____

IN THE PAST 2 YEARS HAVE YOU EXPERIENCED::

- ☐ RECURRING FEVER
- ☐ ANXIETY/TENSION
- ☐ HIGH BLOOD PRESSURE
- ☐ FAMILY BREAK UP
- ☐ BLACK OUTS
- ☐ WEIGHT LOSS
- ☐ NIGHT PAIN
- ☐ DEPRESSION
- ☐ JOB LOSS

ARE YOU PREGNANT OR THINK YOU MAY BE?

☐ YES ☐ NO

ARE YOU SUFFERING FROM ANY OF THE FOLLOWING PLEASE TICK

- ☐ NERVOUSNESS
- ☐ CHRONIC IRRITABILITY
- ☐ INSOMNIA
- ☐ SCALP ACHE
- ☐ HEAD/FACE PAIN
- ☐ HEAD ACHE
- ☐ NAUSEA/VOMITING
- ☐ DIZZINESS
- ☐ LOSS OF CONCENTRATION
- ☐ EYE DISORDER
- ☐ SINUSITIS
- ☐ HAY FEVER
- ☐ LOSS OF TASTE SMELL
- ☐ CHRONIC COUGH
- ☐ ASTHMA
- ☐ FOOD ALLERGIES
- ☐ GENERAL SWELLING
- ☐ NECK PAIN/SYMPTOMS
- ☐ SHOULDER PAIN
- ☐ ARM/ELBOW PAIN
- ☐ ARM WEAKNESS
- ☐ HAND/WRIST PAIN
- ☐ FINGER NUMBNESS
- ☐ BLOOD PRESSURE
- ☐ CHEST PAIN
- ☐ SHORTNESS OF BREATH
- ☐ INDIGESTION
- ☐ UCLER
- ☐ HEART BURN
- ☐ MID BACK SYMPTOMS/PAIN
- ☐ RIB PAIN
- ☐ CONSTIPATION
- ☐ DIARRHOEA
- ☐ ABNORMAL PAIN/CRAMPING
- ☐ KIDNEY DISORDER
- ☐ URINARY PROBLEMS
- ☐ MENSTRUAL DISORDERS
- ☐ TESTICLE PAIN
- ☐ IMPOTENCY
- ☐ SEXUAL DISORDER
- ☐ LOW BACK PAIN
- ☐ BUTTOCKS PAIN
- ☐ HIP JONT STIFFNESS
- ☐ LEG PAIN
- ☐ LEG WEAK/NUMBNESS
- ☐ KNEE PROBLEMS
- ☐ CALF CRAMPING
- ☐ ANKLE SWELLING
- ☐ ANKLE/FOOT WEAKNESS
- ☐ TOOT/TOE SYMPTOMS
- ☐ NUMBNESS
- ☐ SKIN PROBLEMS

FINANCIAL RESPONSIBILITY	SIGN	DATE
I ACKNOWLEDGE THAT PAYMENT IS DUE ON THE DAY OF CONSULTATION	_____	_____