LAKESIDE LASER

Dr Linda Schiller and Associates- 3/45 Central Walk, Joondalup WA 6027- www.lakesidelaser.com.au –PH: 08 9300 0095

Confidential Health History

This information is confidential. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond, we will not accept your case. Please answer all questions **truthfully** even if you think they are irrelevant as only your technician is qualified to determine whether there is a connection to your complaint.

Full name_____ Title_____ Date of birth_____
Address_____ Suburb _____ Postcode_____
Tel _____ Occupation _____
How did you hear about us? _____
Main area of complaint_____
List any treatment you have received for this complaint_____
List any medications you are taking_____
E-mail Add: _____ Have you had laser care before? Y/N
Do you have any private health care? **Yes / No**
Do you have any children? **Yes / No** If yes, number & age of children: _____
Are you comfortable with the use of acupuncture needles? **Yes / No**

Please tick any that have applied within the last 3 months:

[ ] **headache**	[ ] **upper or mid back pain**	[ ] **anxiety**
[ ] **neck pain**	[ ] **nausea/vomiting**	[ ] **fatigue**
[ ] **Neck stiffness**	[ ] **chest pain**	[ ] **depression**
[ ] **numbness in arms**	[ ] **shortness of breath**	[ ] **persistent coughing**
[ ] **double vision**	[ ] **lower back pain**	[ ] **bowel problems**
[ ] **dizziness**	[ ] **leg pain**	[ ] **bladder problems**
[ ] **shoulder/arm pain**	[ ] **numbness in legs or feet**	[ ] **sinus trouble**
[ ] **ringing in ears**	[ ] **blood pressure problems**	[ ] **change in weight**

[ ] **difficulty in rising to walk after sitting**	[ ] **pain while walking**
[ ] **difficulty in standing**	[ ] **pain while standing**
[ ] **difficulty in walking**	[ ] **pain while sitting**
[ ] **difficulty in bending**	[ ] **pain while coughing**

Please tick the following conditions you have or have had:

☐ Alcoholism	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐ Osteoporosis	☐ Stroke
☐ Anaemia	☐ Eczema	☐ Heart disease	☐ Varicose Veins	☐ Psoriasis	☐ Aneurysm
☐ Arthritis	☐ Cancer	☐ Infertility	☐ Thyroid problems	☐ Asthma	☐ Any others…

HAVE YOU EVER:	**YES**	**NO**
Been knocked unconscious	☐	☐
Had a fractured bone	☐	☐
Ever had surgery	☐	☐
Any personal injury or accident	☐	☐
Are you pregnant?	☐	☐

***Have you ever been in an auto accident*? YES/NO**

If yes, state when

CONSENT TO EXAMINATION

I consent to an appropriate physical examination. Consent required by Parent/Guardian if patient is under 16 years of age. I understand that to the best of my knowledge the above to be an accurate health record

Signed _____ **Date** _____

FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE.