11 Principles Pty Ltd

Clinic: 18 Norseman Street, East Victoria Park, WA 6101 (0439 939 508
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 ? ..... ☐ Website .....

☐ Facebook ☐ Media ..... ☐ Other .....

HEALTH AND WELL-BEING PRIORITIES

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

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

IMMUNISATIONS AND DISEASES

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

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

☐ Other ……

ILLNESSES AND CONDITIONS

Please ☑ **TICK** any **CURRENT** illnesses or conditions.
Please place a ☒ **CROSS** next to any **past** illnesses or conditions you no longer suffer from

Skin:

☐ Bruise Easily	☐ Eczema	☐ Psoriasis	☐ Discoloration
☐ Itching	☐ Acne	☐ Rashes type; …….. .	

Musculoskeletal System:

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

Eyes, Ears, Nose & Throat:

☐ Frequent Colds	☐ Sore Throat	☐ Tonsillitis	☐ Sinusitis
☐ Hay fever	☐ Vision Problems	☐ Ringing in Ears	☐ Herpes
☐ Dentures	☐ Dental Problems	☐ Teeth extracted …….. .	

Nervous System – Brain and Nerves:

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

Gastrointestinal:

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

Cardiovascular/Respiratory:

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

Endocrine/Hematology:

☐ Anaemia (low Iron Levels)
☐ Low Blood Sugar (Hypoglycaemia)
☐ Metabolic Syndrome
☐ Hormone Problems
☐ Diabetes Type I or Type II
☐ Sluggish Metabolism
☐ Thyroid Gland (over-active or under-active)
☐ Other …….

Male/Female:

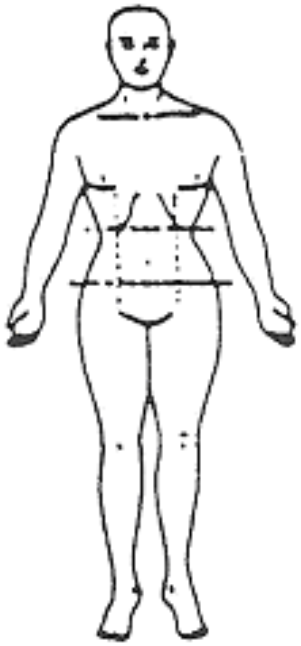
☐ Polycystic Ovary (PCOS)
☐ Premenstrual issues
☐ Poor fertility
☐ Other gynaecological ……
☐ Prostate enlargement
☐ Erectile dysfunction
☐ Low Libido
☐ Incontinence (stress or other)

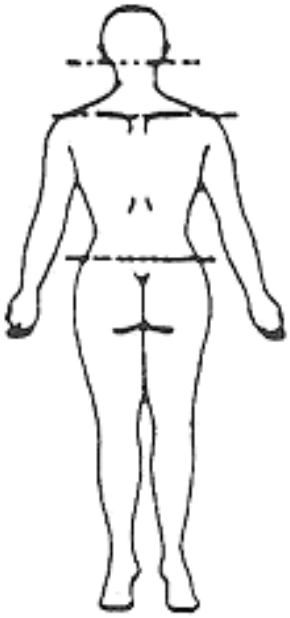
Cancer:

☐ Type …….. ..... ☐ Location …….. .....

☐ Type …….. ..... ☐ Location …….. .....

Please indicate on the diagrams below with a cross or shading, and make a note about, any areas of pain, discomfort or problems.





HOSPITALISATIONS AND ACCIDENTS

Please list all hospitalisations including any **surgeries and operations**. List all other **injuries or traumas** including accidents (e.g. scars) and their location – L or R

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

FAMILY HISTORY

Please indicate if any of your **blood relatives** have suffered from the following disorders or illnesses. Circle the appropriate ones for grandparents.

Cancer (type -), 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 us to determine how your current lifestyle is affecting your overall health/well-being.

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

Activities done at work:.....

.....

Exercise/Activity – describe type and frequency .....

.....

.....

Leisure/Relaxation activities.....

.....

.....

Sleep – describe your sleep habits .....

.....

Smoking Y N Number/day..... Years .....

Alcohol Y N Type..... Intake/day/week .....

What makes you **happy/fulfilled**? .....

.....

.....

What causes **stress** in your life/what **worries** you? .....

.....

.....

.....

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

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*
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

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*
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

Please detail any information that may help the practitioner to understand what you are experiencing at the moment including overwhelming emotions or, recurring thoughts, and any other specific things you would like addressed.

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Office Use:	Date:	Client File:	