O2 WELLNESS

New Patient Form

Name: _____

Address: _____

Email: _____

Phone _____ Mobile: _____

DOB: _____ Gender MALE / FEMALE

Gender: _____

Occupation: _____

Medical Information

Current medications?

_____

_____

Current supplements?

_____

_____

Do you suffer with any ongoing illness? Please list

_____

_____

Do you have any allergies?

_____

Have you had any operations? List dates and procedures.

_____

_____

What are your current health complaints?

Have you had any antibiotics in the last few years? If yes, how often

If female, how many pregnancies have you had?

Dental – do you have any fillings?

Have you had any significant life changes lately?
i.e. Moving house, death in family, changed jobs etc…

Is there a family history of any illness, allergies or disease? Please list.

O2 WELLNESS

Diet Information

What did you eat yesterday?

Breakfast	
Morning tea	
Lunch	
Afternoon Tea	
Dinner	
Snacks	
Beverages	

Does this represent your normal diet? YES | NO

Would you describe the majority of food in your diet as mainly fresh or packaged?

How many glasses of water do you drink a day?

Do you drink tea/coffee? YES | NO If so how much?

Do you drink alcohol? YES | NO If so how much how often?

Do you smoke? YES | NO

Do you crave sugar? YES | NO

Do you get tired in the afternoons? YES | NO

Do you exercise regularly? YES | NO

How many times per week?

Do you sleep well?

Do you suffer from insomnia?

Where do you work?

What are you hoping the outcome of treatments will be?

** PLEASE BRING ANY PREVIOUS TEST RESULTS WITH YOU TO YOUR APPOINTMENT. IF YOUR APPOINTMENT IS VIA SKYPE OR PHONE, PLEASE EMAIL THIS FORM ALONG WITH YOUR TEST RESULTS TO info@o2wellness.com.au

Other important information