majabetts
WOMEN'S WELL-BEING

Confidential Patient Intake Form

Date of initial visit	

Name			
Address			
State		Postcode	
Home Phone		Mobile Phone	
Email			
Date of birth		Age	
Occupation		Marital Status	
Gender		Country of birth	
Health Fund			

If female, are you/could you be pregnant		If you have children, please list their ages	

Primary reason for visit or your principal complaint or health concern
Have you had any medical diagnosis and if so what was it
Any treatment you have had for this matter

		Dates	Details
Any hospital stays			
Any serious adult	illnesses		
	surgery or		
	accidents		
Any serious childhood	illnesses		
	hospital stays		
	surgery		
	accidents		

Do you have or use any medical device (e.g. Pacemaker, CPAP)	
Please list all medications including herbs or supplements	

Do you:

Smoke (how many)		Drink alcohol (units per week)	
Follow any dietary restrictions?		Do you do any regular exercise?	

Any other health concerns?	

Signed	

Your privacy is important. Your information will not be passed to any other practitioner without your express agreement.