BEINGWELL HEALTHCARE

Inspiring individuals and families to live happier and healthier lives

DIAGNOSTIC TESTING

CONFIDENTIAL PATIENT INFORMATION

DATE: ____________________

ABOUT YOU

TITLE ________ GIVEN NAMES __________________________ SURNAME ______________________________

ADDRESS

____

SUBURB________________________________ POSTCODE ______________________________

MOBILE ________________________________ WORK NUMBER ______________________________

EMAIL __________________________________

DATE OF BIRTH _________________________ OCCUPATION ______________________________

EMPLOYER __________________________

PRIVATE HEALTH COVER – ◯ NO ◯ YES HEALTH FUND NAME____________________________________

EMERGENCY CONTACT NAME & PHONE NUMBER

____

HOW DID YOU HEAR ABOUT US ? ◯ WEBSITE ◯ SIGNAGE ◯ FACEBOOK ◯ INSTAGRAM

◯ OTHER ____

◯ Would you like to subscribe to our email marketing database

◯ Would you like to receive an SMS for future appointments? (Chiro/Massage appointments)

◯ Would you like a family member or friend to receive a $10 gift voucher? If YES, please provide an email address (For New Chiro and Massage Clients Only)

NAME ___________________________________ EMAIL ___________________________________

BEINGWELL HEALTHCARE

Inspiring individuals and families to live happier and healthier lives

DIAGNOSTIC TESTS REQUESTED

NAME_______________________________ DATE OF BIRTH _______________________________________

- ☐ FOOD AND / OR INHALANT MOLECULAR ALLERGY TEST (IgE RAST)
- ☐ FOOA AND/OR INHALANT MOLECULAR ALLERGY TEST (ImmunoCap Isac)
- ☐ FOOD INTOLERANCE TESTS (IgG) ◯ *46 Foods* ◯ *90 Foods* ◯ *200 Foods*
- ☐ LEAKY GUT SYNDROME
- ☐ GASTROINTESTINAL PARASITOLOGY TESTS
- ☐ LIVE BLOOD ANALYSIS TESTS
- ☐ NEAUOTRAMSMITTER STRESS PROFILE

HEALTH HISTORY

ARE YOU ON A RESTRICTED DIET? EG. GLUTEN / DIARY FREE, VEGAN, PALEO, LOW FODMAPS ETC.

____

MEDICATIONS / SUPPLEMENTS (INCLUDING HERBAL OR OVER THE COUNTER) CURRENTLY TAKEN:

____

PLEASE TICK IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

☐ HIV/AIDS	☐ Epilepsy	☐ Cancer
☐ Hepatitis A/B/C	☐ Diabetes	☐ Anxiety
☐ Heart Condition	☐ Blood Clotting Disorder	☐ Depression

ALLERGIES / INTOLERANCES – PLEASE LIST: ____

OTHER DIAGNOSED HEALTH CONDITIONS OR MAJOR SURGERY / TRUAMAS – PLEASE LIST:

____

MAJOR FAMILT HISTORY OF ILLNESS (MOTHER / FATHER / SIBLINGS / GRANDPARENTS) – PLEASE LIST:

____

FEMALE ONLY

1. IS THERE ANY POSSIBILITY YOU ARE PREGNANT – YES / NO (PLEASE CIRCLE)
2. IF NOT, ARE YOU TRYING TO CONCEIVE – YES / NO (PLEASE CIRCLE)

BEINGWELL HEALTHCARE
386 MALVERN ROAD, PRAHRAN 3181 | P: (03) 95108866 | F: (03) 9510 7886
1/225 NEPEAN HWY, HIGHETT 3190 | P: (03) 95108866 | F: (03) 9585 7468

RECEPTION@BEINGWELLHEALTHCARE.COM.AU
BEINGWELLHC.COM.AU