Magnolia Natural Medicine
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Dr Dianne Connell BSc Dip Ed Dip Ac Member AACMA (Doctor of Chinese Medicine)

Patient Intake Form

Date:_____

Name:_____ Date of Birth:_____
Address:_____
Postcode:_____ Email address: _____
Phone: (H)_____(W)_____(Mobile)_____
Birthplace (city & country):_____Time of birth :_____
Marital Status:_____ Partner's Name:_____ Children: _____
Children's names and ages:_____
Occupation: _____ Do you enjoy your work? _____
Doctor's name and phone number _____
Emergency contact and phone number: _____
How were you referred to this clinic?_____
Private Health Fund: _____Health care card or pension? _____
What is your presenting condition/reason for visit? _____
_____

Medical History
Past/present illnesses_____
Surgeries_____
Allergies_____
Vaccinations_____
Accidents/traumas_____
Stresses_____
Infections past or present _____
Toxic exposures in the past_____
Number of silver amalgam fillings and root canal fillings in your mouth: _____
Prior treatment(s):_____
Family Medical History (both sides of family):_____
_____
Blood Group:_____ Blood Pressure:_____ Weight:_____ Height:_____
Exercise per week (amount and type): _____
Hobbies and leisure pursuits:_____
Prescription Medicines currently being taken and doses:_____
_____
Nutritional Supplements/Herbs : _____
_____
Amount per day of:
Coffee:_____ Tea: _____ Alcohol: _____
Water:_____ Cola drinks:_____ Cigarettes:_____
Typical Diet:
Breakfast:_____
Lunch: _____
Dinner: _____
Snacks: _____
Do you crave any food(s)? _____