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Welcome to ITH this is the first step on your path to wellness and we look forward to meeting with you in person.

We have created this comprehensive intake form for you to fill out in advance of coming to see us. We realise it might take some time for you to go through, but this will give you an opportunity to think and remember about your past medical history, about your current medical concerns and reasons for seeking our help. Having all this information on paper will be very helpful when you come in, and we will review this together during your medical or nutritional consultation. We have learned that it is often hard for our patients to remember everything when sitting in front of us!

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| **Patient Information** Miss Master (Please circle one) |
| Name:  | Date:  |
| Age:  | DOB: | Gender:  |
| Occupation:  |
| Address Details:  |
| Street No. and Name: |
| Suburb:  | State:  | Postcode:  |
| Home Phone:  |
| Mobile Phone:  | Work Phone: |
| Email Address:  |
| Permission to leave a message on your answering machine or send an SMS: Yes [ ]  No [ ]  |
| Emergency Contact Name:  | Relationship: |
| Emergency Contact Phone Number:  |
| Next of Kin:  | Relationship |
| Next of Kin Contact Phone Number: |
| **Medicare Number:**  | **Position Number:** | **Medicare Expiry Date:** |
| Pension/Health Care Card Number:  | Health Care Card Expiry Date: | Pensioner: Yes/No |
| Preferred Method of contact to confirm appointments: SMS to Mobile phone: [ ]  Message left on answering machine: [ ] **to help the practice provide appropriate health care, are you of aboriginal or torres strait islander origin?**[ ]  aboriginal [ ]  neither aboriginal or torres strait islander[ ]  Torres Strait Islander [ ]  both aboriginal & Torres Strait Islander  |
| **PATIENT CONSENT Circle if applicable only****I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Parent/Guardian)** understand that the information given to my treating doctor/therapist during my consultation is recorded by the doctor/therapist in my medical file. I give permission for information in my file to be forwarded to other medical persons if it is seen to be necessary for my health. I understand that all information in my file can only be accessed in agreement with my treating doctor on the basis that confidentiality and protection of privacy is assured.Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **How did you find out about Invitation to Health?** [ ]  Invitation to Health Facebook Page[ ]  Google/other search engine [ ]  Magazine/Newspaper[ ]  Our Email/Newsletter Communication [ ]  Our Website [ ]  Word of Mouth [ ]  Practitioner referral |
| date  | condition/reason |
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|  |  |
| **Fully immunised:** [ ]  YES [ ]  NO **Please list any vaccines not received:** |
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| **Past Medical History** |
| Check box if you have been diagnosed with any of the conditions below, either presently or in the past (prior to 6 months) |
| **GASTROINTESTINAL CARDIOVASCULAR METABOLIC/ENDOCRINE**[ ]  IRRITABLE BOWEL SYNDROME [ ]  rheumatic fever [ ]  INSULIN RESISTANCE [ ]  INFLAMMATORY BOWEL DISEASE [ ]  other  [ ]  HYPOTHYROIDISM (LOW THYROID)[ ]  pEPTIC ULCER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  HYPERTHYROIDISM (OVERACTIVE)[ ]  gord (REFLUX)  [ ]  bulimia[ ]  coeliac disease **skin diseases** [ ]  anorexia[ ]  colonoscopy [ ]  eczema  [ ]  binge eating disorder when ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  psoriasis  [ ]  type 1 diabetes[ ]  other [ ]  acne [ ]  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  [ ]  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **inflammatory/ neurologic/mood****autoimmune** [ ]  depression[ ]  glandular fever [ ]  anxiety[ ]  rheumatoid arthritis [ ]  headaches [ ]  lupus/sle [ ]  migraines[ ]  immune deficiency disease [ ]  add/adhd [ ]  food allergies [ ]  autism[ ]  environment allergies [ ]  seizures[ ]  multiple chemical sensitivities [ ]  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  latex allergy[ ]  other autoimmune  **respiratory diseases**[ ]  asthma **genital and urinary** [ ]  chronic sinusitis[ ]  frequent urinary tract  [ ]  bronchitis infections  [ ]  pneumonia [ ]  frequent yeast infections  [ ]  tuberculosis  [ ]  sleep apnoea [ ]  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **musculoskeletal or p****AIN**    [ ]  chronic pain [ ]  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |
| **Further Medical History** |
|  **your childhood history dental history** [ ]  lots of sugar as a child [ ]  lots of cavities as a child [ ]  ear infections [ ]  silver mercury fillings [ ]  recurrent strep throat how many? \_\_\_\_\_\_\_\_ [ ]  lots of antibiotics [ ]  gold fillings [ ]  bleeding gums [ ]  stomach aches [ ]  root canals [ ]  gingivitis [ ]  other childhood illnesses [ ]  implants [ ]  floss regularly [ ]  tooth pain   |

**Family History**Family history - have any members of your family had:[ ]  Diabetes [ ]  Depression\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Asthma [ ]  Stroke\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Heart Disease [ ]  Cancer - Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Mental illness [ ]  Smoker\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Other |

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| **Social & Personal History** (tick all that apply) |
| **ethnicity**: australia is a genuinely multicultural society. to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds – do you identify as someone from a culturally and /or linguistic diverse background?Yes [ ]  No [ ]   |
| **If Yes, please give detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **sleep** How many hours sleep does your child have at night? ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_what time does he/she go to bed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ wake up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_does he/she have issues settling to sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_does he/she have issues with waking through the night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you co sleep with your child often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Exercise – Does your child participate in activities outside of school?** |
| activity  | type | how often each week |
|  |
|  |
|  |
| **Environmental or Other Exposures and Detox Assessment** |
|  history of:adverse reaction to: [ ]  jaundice (turning yellow)  [ ]  gilbert’s syndrome or a liver disorder[ ]  monosodium glutamate (MSG) explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  aspartame (nutrasweet)[ ]  bananas [ ]  garlic [ ]  onion [ ]  cheese exposure to harmful chemcials such as:[ ]  citrus foods [ ]  chocolate [ ]  herbicides[ ]  sulphite containing foods [ ]  insecticides (frequent visits of exterminator)(dried fruit, salad bars)  [ ]  pesticides[ ]  preservatives (sodium benzoate) [ ]  organic solvents[ ]  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  heavy metals [ ]  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  chemical name/date/length of exposure [ ]  dry clean your clothes frequently\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  lived in a damp or mouldy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ environment or had other mould exposure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  do you have any pets or farm animals \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  electromagnetic radiation [ ]  work with oil based paint - artist or painterhome enVIRONMENT, are you exposed to: [ ]  chemicals [ ]  mould   |
| **Current Health Reason for this Visit?** Tick all that apply[ ]  General health, prevention and wellbeing[ ]  Chronic illness/condition (heart disease, diabetes, chronic pain of > 3 months etc)specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Acute illness – specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Surgery-related – specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Other – specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **What type of Service are you here for?** (Check all that apply) [ ]  GP Consult [ ]  Biomedical Consult [ ]  Nurse Consult [ ]  Traditional Chinese Medicine [ ]  Acupuncture [ ]  Osteopathy [ ]  Kinesiology [ ]  Psychology[ ]  Nutrition [ ]  Naturopathy [ ]  Bach Flowers [ ]  Other  |
| **Medical History** |
| What brings you to Invitation to Health? |
|  |
| If you had 3 wishes for your visit today, what would they be? |
|  |

**SYMPTOM REVIEW –** Please tick if you have any of the following symptoms:

**sKIN pROBLEMS** **hEAD, EYES & EARS** **CARDIOVASCULAR**

[ ]  Acne [ ]  Distorted Smell [ ]  CHest Pain

[ ]  Athlete’s foot [ ]  distorted taste [ ]  Breathlessness

[ ]  bumps back of arms [ ]  bad breath [ ]  palpitations

[ ]  cellulite [ ]  ear fullness [ ]  pain in calves

[ ]  dandruff [ ]  ear pain [ ]  swollen ankles

[ ]  dark circles under eyes [ ]  ear ringing [ ]  varicose veins

[ ]  ears get red [ ]  hearing problems [ ]  LIGHT HEADEDNESS

 [ ]  RECURRENT SORE THROAT [ ]  FAINTING

 [ ]  HOARSENESS

[ ]  easy bruising [ ]  eye pain/IRRITATION **respiratory**

[ ]  eczema [ ]  vision disturbance [ ]  snoring

  [ ]  sinus [ ]  cough

[ ]  cold sores [ ]  migraine [ ]  coughing up blood

[ ]  hives [ ]  headache [ ]  hayfever

 [ ]  noise sensitive [ ]  sinus fullness

[ ]  change in moles [ ]  jaw pain [ ]  nasal stuffiness

[ ]  oily skin **nails** [ ]  nose bleeds

[ ]  psioriasis [ ]  bitten [ ]  post nasal drip

[ ]  rash [ ]  brittle [ ]  SHORTNESS of breath

[ ]  sensitive to bites [ ]  fungus [ ]  at rest

[ ]  shingles [ ]  ridges [ ]  with exercise

[ ]  skin itching [ ]  thickened

[ ]  skin drynress [ ]  white spots/lines

[ ]  strong body odour

**DIGESTION MUSCLE/BONE ENDOCRINE/IMMUNE**

[ ]  BLOATING AFTER EATING [ ]  MUSCLE TWITCHING [ ]  COLD HANDS/FEET

[ ]  BLOOD IN STOOLS [ ]  MUSCLE PAIN [ ]  COLD/HEAT INTOLERANCE

[ ]  BURPING [ ]  JOINT PAIN OR SWELLING [ ]  FATIGUE

[ ]  CONSTIPATION [ ]  JOINT STIFFNESS [ ]  WEIGHT GAIN

[ ]  ANAL ITCHING [ ]  BACK PAIN [ ]  GET SICK A LOT

[ ]  TROUBLE CHEWING **MOOD/NERVES** [ ]  SWOLLEN LYMPH NODES

[ ]  DIARRHEA [ ]  DIFFICULTY CONCENTRATING [ ]  HAIR LOSS

[ ]  DIFFICULTY SWALLOWING/PAINFUL [ ]  DIFFICULTY WITH BALANCE **URINARY**

[ ]  DRY MOUTH [ ]  DIFFICULTY WITH JUDGEMENT [ ]  HESITANCY

[ ]  FISSURES [ ]  DIFFICULTY WITH MEMORY [ ]  FREQUENT uti

[ ]  HEARTBURN (REFLUX) [ ]  DIZZINESS (SPINNING) [ ]  PAIN/BURNING

[ ]  HAEMORRHOIDS [ ]  SUICIDAL THOUGHTS [ ]  URGENCY

**INTOLERANCE TO**: [ ]  depression [ ]  LEAKING

[ ]  LACTOSE [ ]  NUMBNESS [ ]  BLOOD IN URINE

[ ]  ALL MILK PRODUCTS [ ]  panic attacks

[ ]  GLUTEN [ ]  anxiety

[ ]  CORN [ ]  OTHER PHOBIAS

[ ]  EGGS [ ]  PARANOIA

[ ]  fatty foods [ ]  HALLUCINATIONS

[ ]  Other ­­­­­­Click here to enter tex [ ]  SEIZURES

[ ]  TREMOR

**SYMPTOM REVIEW continued –** Please tick if you have any of the following symptoms:

[ ]  yellow eyes/skin

[ ]  ABDOMINAL PAIN

[ ]  MUCOUS IN STOOLS

[ ]  NAUSEA

[ ]  STRONG STOOL ODOR

[ ]  UNDIGESTED FOODS IN STOOLS

[ ]  VOMITING

[ ]  UNINTENTIONAL WEIGHT LOSS

[ ]  CAR SICKNESS

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| **Nutrition and Diet** |
| nutrition historyhave you ever had a nutrition consultation? [ ]  yes [ ]  noWas/is this child breastfed? [ ]  yes [ ]  nofor how long? ­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Did you use formula? [ ]  yes [ ]  noif so what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Did you have to change formulas to get the right one? if so please give details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Does your child follow any special diet?  [ ]  yes [ ]  no describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Does the whole family follow this way of eating?  [ ]  yes [ ]  nodo you have any concerns about your childs diet? [ ]  yes [ ]  noPLEASE EXPLAIN YOUR CONCERNS (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_how often does your child have a bowel movement? (if known)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_is your child’s diet high in junk food and/or take-away? [ ]  yes [ ]  nodo you read food labels? [ ]  yes [ ]  no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_do you cook? [ ]  yes [ ]  no, if no who does the cooking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_how much water does your child drink every day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CHECK ALL THE FACTORS THAT APPLY TO YOUR CURRENT LIFESTYLE AND EATING HABITS:[ ]  FAST EATER [ ]  ERRACTIC EATING PATTERNS [ ]  EAT TOO MUCH[ ]  LATE NIGHT EATING [ ]  DISLIKE HEALTHY FOOD [ ]  TIME CONSTRAINTS[ ]  NON AVAILABILITY OF HEALTHY FOODS  [ ]  POOR SNACK CHOICES[ ]  EAT TOO MUCH UNDER STRESS[ ]  EAT TOO LITTLE UNDER STRESS[ ]  RELIANCE ON CONVENIENCE ITEMS[ ]  FAMILY MEMBERS DON’T LIKE HEALTHY FOODS[ ]  FAMILY MEMBERS HAVE SPECIAL DIETARY NEEDS OR FOOD PREFERENCES[ ]  LOVE TO EAT[ ]  only EATs BECAUSE he/she HAs TO[ ]  HAs A NEGATIVE RELATIONSHIP WITH FOOD[ ]  STRUGGLE WITH EATING ISSUES[ ]  EMOTIONAL EATER (EAT WHEN SAD, lonely, depressed)[ ]  eat in the middle of the night |
| **Nutritional Supplements (vitamins, herbs, homeopathy)****\*PLEASE BRING ALL YOUR SUPPLEMENTS/MEDICATIONS TO YOUR FIRST APPOINTMENT\*** |
| supplement/brand  | Reason for use |
|  |  |
|  |  |
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|  |  |
| **Readiness to Change** |

**OUR PRACTICE IS SCENT-FREE**.

*The chemicals used in scented products can make some people sick, especially those with fragrance sensitivities, asthma, allergies and other medical conditions.*

***Please Do Not Wear Perfume or Heavily Scented Body Care Products When Attending This Surgery***

**APPOINTMENT CONFIRMATION & CANCELLATION POLICIES**

Effective from the 1st December, 2018

Invitation to Health advises we have implemented new policies for Appointment Reminders and Confirmation of Appointments to maximise doctor and practitioner availability for our patients.

**PAYMENT POLICY**

\* Please note this applies to all integrative GPs.

For new patients: At the time of booking your first appointment, your credit card details will be taken and the amount of the consultation fee held against your card for a period of 10-15 days (depending on your card provider) as a guarantee for your scheduled appointment. At the end of this period, the funds shall be released back to you until the day of your appointment, and your card information will be held and utilised in the event of cancellation or non-arrival fees.

**APPOINTMENT CANCELLATION POLICY**

\* Please note this applies to all GPs & all therapists.

All appointment cancellations are required to be made a **minimum of 2 BUSINESS DAYS** prior to your appointment to avoid the **full consultation fee**. ie: If your appointment is scheduled on a Monday, notice to cancel is required by 5pm Thursday of the week prior. This includes “No Shows”. **The** **full consult fee will be debited from the credit card stored** and no future appointments shall be made until the cancellation fee has been paid.

**SMS REMINDER POLICY**

\* Please note this applies to all appointments within our practice.

**5 days** – A reminder text message will be sent to you 5 days prior to your appointment. Please reply to confirm your appointment or call Reception to reschedule. **Failure to reply prior to 2 BUSINESS DAYS**  **in advance of your appointment will result in your appointment being cancelled** and offered to patients on our waiting list. **The** **full consultation fee will be debited from the credit card on file.**

**24 Hours** – A second reminder SMS will be sent 24 hours prior to your appointment as a reminder (no response required).

All patients without mobile phones will be contacted at the same intervals on their landline.

Please sign to acknowledge the above policies.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_