Mojo KLINIK

Confidential Patient Questionnaire

Ph: 0291338500 Suite 11/40 Yeo St, 2089, Neutral Bay. www.mojoklinik.com

THE MOJO KINIK

Please fill out the following questionnaire. Please remember that all your information is confidential and is for the assessment & treatment procedure of patients for practitioners.

Dr. Maria Mackey Date / / Time :

Title (Please circle one) Ms. Mr. Mrs. Miss. Dr. Prof. Sir.

First Names: Surname:

D.O.B: Height (cm): Weight (kg):

Address:

Town / Suburb: State: Post Code:

Home: Work: Mobile:

Email Address:

Next of Kin:

Relationship: Phone number:

Email Address:

Medicare Number: Expiry: / / IRN:

Pensioner/HCC no. & exp:

☐ ← **Please tick this box if you would like to receive a 24 hour SMS reminder prior to your appointment**

Please list your reasons for this appointment (problems you are experiencing)

What do you believe this is due to?

Have you tried any treatment(s) for problem(s) listed above? If so, please include any relevant test/consults/ investigation/letters to your appointment

When was the last time you felt well?

What do you expect from your consultation today?

Medical History

Please circle what is relevant to you

Illness/Medical Problem	Present	Past
Heart/Vascular Disorder	YES	YES
Blood Disorder	YES	YES
High Blood Pressure	YES	YES
Cancer	YES	YES
Arthritis	YES	YES
Diabetes	YES	YES
Liver Disease	YES	YES
Kidney Disease	YES	YES
Asthma	YES	YES
Epilepsy	YES	YES
Hepatitis	YES	YES
Glandular Fever	YES	YES
Dysentery	YES	YES
Sexually Transmitted Diseases (please specify)	YES	YES
Other Conditions (please specify)	YES/NO	YES/NO
Operations (please specify)	YES/NO	YES/NO
Exposure to chemicals or Toxins (please specify)	YES/NO	YES/NO
Pregnancies	YES/NO	YES/NO
Amalgam Fillings	YES/NO	YES/NO
Frequent Antibiotic use	YES/NO	YES/NO
long term medications (includes contraceptive pill)	YES/NO	YES/NO

Pathology& Screening History

Screening Test/Pathology	Date	Result
Mammogram/ Breast Ultrasound		
Pap Smear		
Bone Density		
Cholesterol		
PSA (Prostate Blood Test)		

Nutritional Supplements (vitamins, minerals etc.), **Herbal Medicines, Homoeopathic Remedies**

Name	**Dosage**

Current Medications (prescription & non-prescription)

Name	**Dosage**

Allergies & Sensitivities (including medications, food, dust mites, grass, chemicals etc.)

Allergies/Sensitivities	Treatment

Social History

Occupation	
Marital Status	
Cigarettes/ Tobacco (strength & amount per day)	
Alcohol (type & amount per day)	
Recreational Drugs	
Exercise (type, duration & frequency)	
Relaxation Techniques (Meditate, read, yoga etc.)	

Diet

Do you follow a specific type of diet?	YES/NO
If yes, please specify(e.g. low fat, blood group, vegetarian etc.)	

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What did you eat yesterday?

Breakfast	
Lunch	
Dinner	
Snacks	

Sugar(tsp/day)	Tea OR Coffee (cups/day)	Soft Drinks(per day)

Water (amount/glasses per day) Other drinks

Was this a typical day? YES/NO

Please list foods that you **crave**	Please list foods that you **avoid**

Immunisation History (Please record any immunisations you have received)

TYPE	**DATE**	**TYPE**	**DATE**

Current Symptoms

Please tick the box to the right of any condition(s) you are **currently experiencing**

General

- Fatigue ☐
- Apathy/Lethargy ☐
- Hyperactivity ☐
- Poor Appetite ☐
- Hypoglycaemia ☐
- Poor Sleep/insomnia ☐
- Sleep apnoea ☐
- Excessive thirst ☐
- Stress ☐
- Easy Bruising ☐

Weight

- Weight gain ☐
- Difficulty losing weight ☐
- Fluid retention ☐
- Binge eating ☐
- Compulsive eating ☐
- Craving for certain foods ☐
- Aversion of certain foods ☐
- Weight loss ☐
- Eating disorders ☐

Nervous System

- Headaches ☐
- Migraines ☐
- Faintness ☐
- Dizziness ☐
- Numbness ☐
- Tingling, pins & needles ☐
- Poor co-ordination ☐
- Feel cold easily ☐
- Cold hands & feet ☐

Eyes

- Water/itchy ☐
- Painful/red ☐
- Sticky eyes ☐
- Blurred vision ☐
- Losing vision ☐
- Dry eyes ☐

Ears

- Itchy ☐
- Aches ☐
- Infections ☐
- Discharge ☐
- Tinnitus ☐
- Ringing ☐
- Hearing loss ☐

Digestive System

- Indigestion
- Heartburn/reflux
- Bloating
- Feel full easily
- Burping
- Flatulence
- Abdominal pain
- Stomach cramps
- Nausea
- Vomiting
- Hard to swallow
- Diarrhoea
- Constipation
- Haemorrhoids
- Mucus
- Rectal bleeding
- Anal itching

Gynaecological

- PMS/PMT
- Breast Pain
- Breast Lumps
- Breast implants
- Regular periods
- Irregular periods
- No periods
- Heavy periods
- Menstrual clots
- Period pain
- Intercourse pain
- Vaginal soreness
- Vaginal irritation
- Discharge
- Thrush
- Menopausal
- Hot flushes
- Sweats
- Vaginal dryness

Heart/Circulation

- High blood pressure
- Low blood pressure
- High cholesterol
- Chest Pain
- Palpitations
- Arrhythmia
- Swelling of ankles
- Poor circulation
- Calf pain with exercise
- Varicose veins

Lungs

- Short of breath
- Cough
- Sputum
- Blood
- Chest tightness
- Wheeze

Genito-Urinary

- Frequent urination
- Passing large amounts of urine
- Burning during urination
- Discomfort during urination
- Discharge
- Blood in urine
- Urgent urination
- Kidney Pain
- Difficulty passing urine
- Passing urine frequently at night
- Incontinence
- Loss of libido
- Erectile dysfunction/ impotence

Joints & Muscles

- Pain
- Swelling
- Stiffness
- Arthritis
- Neck problems
- Back problems
- Cramps/spasms
- Muscle twitching
- Muscle tension
- Weak muscles
- Gout

Skin

- Acne/pimples
- Eczema
- Dermatitis
- Psoriasis
- Rosacea
- Rashes
- Hives
- Dry skin
- Poor healing
- Excessive sweat
- Body odour
- Dandruff

Hair & Nails

HAIR

- Dry hair
- Hair loss

NAILS

- Soft
- Break easily
- White spots
- Ridged
- Fungal infection

Mouth & Throat

- Mouth ulcers
- Cold sores
- Mouth cracks(corners)
- Sore throat
- Hoarseness
- Loss of voice
- Gum disease/bleeding
- Feeling of lump in throat
- Loss of taste sensation
- Bad breath

Nose

- Congested
- Blocked
- Poor sense of smell
- Sinus problems
- Hay fever
- Allergies
- Sneezing
- Excessive mucus
- Post-nasal drip

Emotions

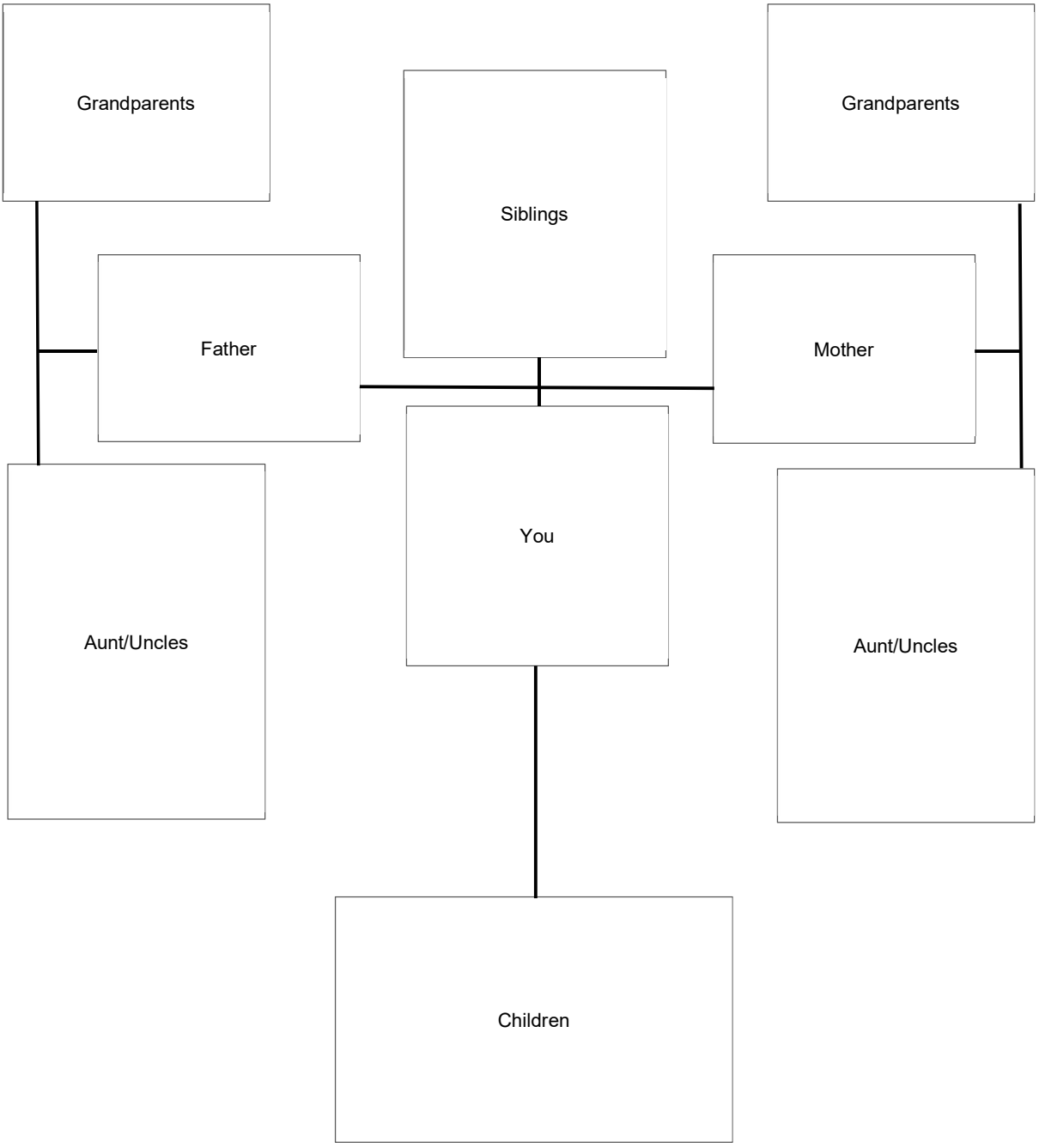
- Anxiety
- Depression
- Mood swings
- Panic attacks
- Anger
- Irritability

Mind

- Poor memory
- Poor concentration
- Confusion
- Poor comprehension
- Brain fog

Family History

Please complete the chart below indicating only chronic or significant illnesses (e.g. diabetes, asthma, cancer, arthritis, heart disease, blood pressure etc.) within the appropriate box on the family medical history tree below.



General Acknowledgement & Consent Form

I, _____ of _____

_____ (address)

understand that some of the diagnostic test, treatments & products administered by practitioners at The Mojo Klinik may be outside the parameters of conventional medicine in Australia. They fall into the category of Natural or Complementary Medicine. I understand that these diagnostic tests, treatments and products are supported by empirical knowledge are safe, are widely & successfully used by Integrative Medical practitioners in centres in Australia & overseas, and are only prescribed with the utmost care. Some diagnostic tests & treatments offered at The Mojo Klinik are not covered by medicare or private health insurance funds. All Mojo Klinik practitioners are members and active participants of their respective professional Colleges & Associations.

I am attending The Mojo Klinik of my own free will & consent, and exercise my right to discuss * choose any useful & suitable treatment(s) made available to me. I understand that Mojo Klinik practitioners may recommend & dispense items that are yet to be regulated by Therapeutic Goods Administration (TGA), should the practitioner deem that such products or treatments are in my best interest. If there are any risks associated with using unregulated products or treatments, The Mojo Klinik practitioner(s) will make me fully aware of those risks & provide me with sufficient information to make an informed decision.

Patients Name: Witness's Name:

Signature: Signature

Date: Date: