PATIENT DETAILS FORM

Doctor's Name: _____

Patient Details

Mr/Mrs/Miss/Ms Surname: _____

Given name:_____ Preferred Name: _____

Date of Birth: _____ Occupation: _____

Address: _____

Suburb:_____ Postcode: _____

Contact Details

Phone (Home):_____ Phone (Work): _____

Email Address: _____ Mobile: _____

I,_____ hereby consent to the contact details I have provided to be used for any correspondence including texting of appointment reminders, email correspondence including results.

Signature:_____ Date: _____/_____/_____

Marital Status: _____ Number of Children:_____

Gender: _____ Indigenous Status:_____

Medicare No: _____ Ref No.:_____ Expiry Date: _____

Health Care Card No:_____ Pension Card.: _____ Expiry Date: _____

Source of Referral:_____

Emergency Contact Details

Emergency Contact Person: _____

Relationship to Patient: _____

Emergency Contact No (other than phone number above): _____

I,_____ hereby consent to the above-named person being contacted in the event that I am unavailable to be contacted.

Signature:_____ Date: _____/_____/_____

DRJAA'S MEDICAL HEALTH

GENERAL SCREENING QUESTIONNAIRE

Patient Name: _____

Allergies: _____

Presenting Problems: _____

Medical History: _____

Surgical History: _____

Current Medications: _____

Current Supplements (vitamins/herbs): _____

Do you smoke? Yes / No
If Yes, how many per day: _____

Do you drink alcohol? Yes / No
If Yes, how much per day: _____

Rate each of the following symptoms based upon your health profile over the last 30 days

Point Scale:
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have it, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe
Blank = Not Sure

DIGESTIVE TRACT	0	1	2	3	4	Not Sure
Nausea or vomiting						
Diarrhoea						
Constipation						
Bloated feeling						
Belching or passing gas						
Heart burn						
Intestinal / stomach pain						
Sub Total						
EARS	0	1	2	3	4	Not Sure
Itchy ears						
Earaches or infections						
Drainage from ear						
Ringing in ears						
Sub Total						
EMOTIONS	0	1	2	3	4	Not Sure
Mood swings						
Anxiety or nervousness						
Anger or aggressiveness						
Depression						
Sub Total						
ENERGY / ACTIVITY	0	1	2	3	4	Not Sure
Fatigue or sluggishness						
Apathy or lethargy						
Hyperactivity						
Restlessness						
Sub Total						
EYES	0	1	2	3	4	Not Sure

DRJAA'S MEDICAL HEALTH

Watery or itchy eyes						
Swollen or sticky eyelids						
Bags under eyes						
Blurred or tunnel vision						
Sub Total						
HEAD	0	1	2	3	4	Not Sure
Headaches						
Faintness						
Dizziness						
Insomnia						
Sub Total						
HEART	0	1	2	3	4	Not Sure
Irregular heartbeat						
Rapid or pounding heartbeat						
Chest pain						
Sub Total						
JOINTS / MUSCLES	0	1	2	3	4	Not Sure
Pain or aches in joints						
Arthritis						
Stiffness or limited movement						
Pain or aches in muscles						
Weakness or tiredness						
Sub Total						
LUNGS	0	1	2	3	4	Not Sure
Chest congestion						
Asthma or bronchitis						
Shortness of breath						
Difficulty breathing						
Sub Total						
MIND	0	1	2	3	4	Not Sure
Poor memory						
Confusion or poor comprehension						
Poor concentration						
Poor physical coordination						
Difficulty making decisions						
Stuttering or stammering						
Slurred speech						
Learning disabilities						
Sub Total						
MOUTH / THROAT	0	1	2	3	4	Not Sure
Chronic coughing						
Gagging						
Sore throat or voice loss						
Swollen or discoloured tongue						
Canker sores						
Sub Total						
NOSE	0	1	2	3	4	Not Sure
Stuffy nose						
Sinus problems						
Hayfever						
Sneezing attacks						
Sub Total						
SKIN	0	1	2	3	4	Not Sure
Acne						
Hives or rashes						
Hair loss						

Hot flushes						
Excessive sweating						
Sub Total						
WEIGHT	0	1	2	3	4	Not Sure
Binge eating / drinking						
Craving certain foods						
Excessive weight						
Compulsive eating						
Water retention						
Underweight						
Sub Total						
OTHER	0	1	2	3	4	Not Sure
Frequent illness						
Frequent urination						
Genital itch or discharge						
Sub Total						
TOTAL						

Comments: _____

_____

_____

	YES	NO
Have you ever been treated with antibiotics?		
Have you ever had a yeast infection?		
Do you eat or crave sweet foods?		
Do you have food allergies?		
Have you ever had food poisoning?		
Do you or have you consumed alcohol regularly?		
Have you ever taken Tagamet or Zantac?		
Do you take aspiring, panadeine or other pain killers?		
Do you take any other drugs regularly?		
Are you often in contact with organic chemicals?		
Do you react to strong perfumes, car exhaust, etc?		
Do you or have you ever smoked tobacco?		
Are you exposed to passive cigarette smoke?		
Do you consume caffeine?		

LIVER DETOXIFICATION TEST (LDT) SCREENING QUESTIONS		
A certain percentage of patients will experience reactions during the LDT. The reactions include, but are not limited to: shakiness, headaches, nausea, palpitations, light-headedness and sweating. The following questions will help isolate those patients who may experience these reactions.		
	YES	NO
Do you react when you consume caffeine?		
Are you sensitive to food additives like M.S.G.?		
Do you have a history of liver problems?		
If yes, describe:		
Are you currently taking any drugs?		
If yes, list:		

PATIENT GENERAL CONSENT FORM

Doctor's Name: _____

I, (Patient's Name): _____

Of (Patient's Address): _____

Understand that:

- Some of the accessory functional pathology tests, treatments and products administered by practitioners at *Dr Jaa's Medical Health* may be outside the parameters of conventional medicine in Australia. They include IM, IV and PR applications.
- These tests, treatments and products fall into the category of Natural or Complementary Medicine.
- These functional tests, treatments and products are supported by empirical knowledge and in many cases by research data.
- That these tests, treatments and products are safe, are widely and successfully used by Integrative Medical Practitioners in centres in Australia and overseas, and are only prescribed with utmost care.
- Some functional pathology tests and treatments offered at *Dr Jaa's Medical Health* are not covered by Medicare or private health insurance funds.
- All *D Jaa's Medical Health* practitioners are members and active participants of their respective professional colleges.
- I also understand that practitioners may benefit either directly or indirectly from tests recommended at this practice.
- The treatment may not be regulated by the TGA (Therapeutic Goods Administration).

I am attending *Dr Jaa's Medical Health* of my own free will and consent and exercise my right to discuss and choose any useful and suitable treatment(s) made available to me.

Information obtained at the clinic can, and may be used, de-identified for research and publication.

Confirmation of Consent:

Patient Consent:_____

Date:_____

NUTRIENT CONSENT

I, (Patient's Name): _____

Understand that nutrient supplements may be prescribed as part of my treatment plan:

- Some of the nutrients prescribed may be higher doses than that specified by the recommended daily intakes by NHMRC (National Health and Medical Research Council)
- It is important I take these prescribed nutrients as directed by my doctor.
- I will return for review of my health at a data specified by my doctor, and if I fail to attend these reviews I will no longer take any of the supplements prescribed by my doctor.
- I understand these supplements are only prescribed for me and not to be used for anyone else.
- I understand that prolonged taking of certain supplements at high doses without medical supervision could lead to adverse health outcomes such as nerve and thyroid disorders. I will direct any question of concern to my Doctor during my consultations.
- Some of the products are not TGA listed and may need a SASB form willed on my behalf.
- The Pfeiffer/Iodine/Amino Acid Nutritional protocol includes higher doses of B6, iodine, lithium, selenium and molybdenum. These does need to be monitored. I will stop the therapy and inform my doctor if I experience any of the following:
    - Tingling in hands, feet and tongue
    - Metallic tastes in the mouth
    - Undue fatigue or agitation
    - Worsening of my condition