Beach Street Centre

Your Health & Wellness Clinic

Greg de Jong: Physiotherapist
& Nutritionist

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Heart Math Assessment

By accurately and in detail completing this questionnaire I can make more efficient use of your therapy session. Thank you for your time in filling out the new patient questionnaire. You can leave out any questions if you wish, or write more if you feel there is any other relevant information you need add.

Name:	DOB
Address	
Phone:	Email
If you have a smart phone is it Apple/Android/Microsoft based? (Knowing this helps with providing information on Apps that may help with your Condition)	
Private Health Fund:	No:
Medicare No. (if on a Care Plan)	
Height:	Weight
Today's Date:	

Please provide a brief description of you main reason for this appointment:

Which of the following are you interested in helping with Heartmath (circle)?	
General Anxiety Anger Study and Exams Emotional Control Relationship Management Social Anxiety Eating Disorders Smoking Recreational Drug Addiction Other Addictions (Specify Below) ____________________________ Other (Specify Below) ____________________________	Depression Stress Pain Self-Esteem Performance Anxiety Sleep Weight Loss Alcohol Addiction Specific Health Condition (Specify Below) ____________________________

Do you smoke and if so, how many/per day?	
Do you drink alcohol and if so, how many/per day?	
How many serves of caffeine (coffee, energy drinks) per day?	

Have you been Stressed, Anxious or Depressed in the last week (circle which if Yes)?

Have you been Stressed, Anxious or Depressed in the last 6 months (circle which if Yes)?

Are you Stressed, Anxious or Depressed more often than not? (circle which if Yes)?

Do you suffer from Schizophrenia or Bipolar Disorder?

Circle any Medical Conditions that you/ your child has or

Box Medical Condition where there is a Family History?

Heart Disease	High Blood Pressure	Low Blood Pressure	Diabetes
Asthma	COPD	Chronic Fatigue	Fibromyalgia
Cancer	Epilepsy	Depression	Anxiety
Osteoarthritis	Rheumatoid Arthritis	PMS	Menopause
Ankyl. Spondylitis	TMJ (Jaw) Problems	Hyperthyroid	SLE
Hypothyroid	Dementia	Alzhiemers Dis.	MS
Osteoporosis	Osteopenia	Mental Health	Incontinence
Irritable Bowel	IBD	Other Gastro (List)	Liver Disease
Psoriasis	Eczema	Lymphoedema	Endometriosis
Migraines	Headaches	ADHD	Autism

Any Other Medical Condition/Surgery?

Do you have any current illness such as cough, cold or flu? Yes/No
Is there any possibility you may be pregnant? Yes/No

List your Current Medication including Nutritional/Herbal Supplements?

I, ______________________________ consent to the use of Heartmath for

________________________________ (add name of child where relevant) for the purposes outlined above:

________________________________ (Signature) _________________ (Date)