



# Jeanine Mewburn Remedial Therapy

## Lymphoedema Treatment



### Medical form - Confidential

Title: \_\_\_\_\_ Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_

Address: \_\_\_\_\_ Postcode: \_\_\_\_\_

Phone (h): \_\_\_\_\_ Phone (w): \_\_\_\_\_

Mobile: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: MALE/FEMALE

If under 18 years of age, parents / guardian names: \_\_\_\_\_

General Practitioner: \_\_\_\_\_ Suburb: \_\_\_\_\_

**Do you use the Internet?** YES/NO Email address: \_\_\_\_\_

**Do you have private health insurance that covers massage therapy?** YES/NO \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

**How would you like to be reminded of your appointments?** Phone (Hm/Mob/Wk)      Email      None

**What is your current occupation?** \_\_\_\_\_

**Do you do any regular exercise?** YES/NO If so, what type?

**Do you suffer from any medical condition/s?** YES/NO

If YES please specify: \_\_\_\_\_

**Are you currently taking any medication/s?** YES/NO

If YES please specify: \_\_\_\_\_

**Are you allergic to any substances or medications?** YES/NO

If YES please specify: \_\_\_\_\_

**Do you suffer any of the following medical conditions?**

- |   |  |
|---|--|
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Low back             | <input type="checkbox"/> Low Blood Pressure  |
| <input type="checkbox"/> Neck / Shoulder pain | <input type="checkbox"/> Heart condition     |
| <input type="checkbox"/> Headache             | <input type="checkbox"/> Osteoporosis        |
| <input type="checkbox"/> Anxiety / Depression | <input type="checkbox"/> Other               |
| <input type="checkbox"/> Migraine             |  |

**Referring doctor:** \_\_\_\_\_

**Have you had surgery?** \_\_\_\_\_

Specify: \_\_\_\_\_

**Did you have swelling after surgery?** YES/NO

**Did the swelling go down?** YES/NO

**Radiotherapy:** YES/NO

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

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

**Chemotherapy:** YES/NO

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

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

**Lymph nodes removed:** YES/NO

How many? \_\_\_\_\_

**Medication:** \_\_\_\_\_

**Part of the body affected:** \_\_\_\_\_

**What do you think triggered the swelling?** \_\_\_\_\_

When did swelling start: \_\_\_\_\_

**Did you seek immediate treatment?** YES/NO

Specify: \_\_\_\_\_

**Have you had infection?** YES/NO

Specify: \_\_\_\_\_

**Are you taking diuretics?** YES/NO

Specify: \_\_\_\_\_

**Have you used a pump?** YES/NO

Specify: \_\_\_\_\_

**Are you wearing compressive garment?** YES/NO

Specify: \_\_\_\_\_

**Pain severity:**

\_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5 \_\_\_ 6 \_\_\_ 7 \_\_\_ 8 \_\_\_ 9 \_\_\_ 10

**Disability:**

\_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5 \_\_\_ 6 \_\_\_ 7 \_\_\_ 8 \_\_\_ 9 \_\_\_ 10

It is the policy of JEANINE MEWBURN REMEDIAL THERAPY that payment of consultation fees is required at the time of consultation.

We would appreciate a minimum 24 hour notice for cancellation or rescheduling of appointment, so we do not deprive others of a vacancy

**Please read our privacy statement below prior to signing this document.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### WELCOME! YOUR PRIVACY IS IMPORTANT TO US...

This practice takes great care to ensure that our information records are accurate and treated with full regard to the privacy of our patients. We are pleased to discuss our procedures with you, and to amend any inaccuracies in your records. We only collect information from our patients that are necessary for good health care, and aim to ensure that any information we hold is accurate, complete and up-to-date.

The health information we hold helps us provide our patients with the best possible health care, and is normally disclosed only to others – such as your doctor – involved in your treatment. If we need to disclose information about you to people other than those associated with your treatment, we will seek your permission first. Occasionally we may be involved in research on health issues. If any data from this practice is used in research, it will not include information that identifies our patients, unless special circumstances apply.

Health information from this practice is also sometimes used for quality assurance or clinical audit activities, which help improve the treatment and service we provide. Data used for these purposes is normally de-identified to protect the privacy of our patients.

This practice has systems in place to protect the security of our health records. Nobody other than our staff has access to these records, they are kept in a secure location, and no unauthorized person has access to them. Records of patients who no longer attend this practice are destroyed or permanently de-identified when no longer needed.

In line with normal business procedures, this practice maintains contact lists and mailing lists of people (other than patients) with whom we do business or wish to contact from time to time.

This practice is bound by the Privacy Amendment (Private Sector) Act 2000, and operated in accordance with the Code of Conduct of the Australian Traditional Medicine Society. If you would like to discuss any aspects of our privacy policy, or review your health records, please advise Jeanine.