157 B Colwill Rd
Massey
Auckland 0614

Case History Adult **Date:**

Name:	Date of Birth:
Address:	Occupation:
Contact: Tel H: Tel W: Tel M:	GP (Name & Address):
Email:	How referred:

Covid 19 Screen: □ no concerns

Health Conditions:
Please check if you have had any of the following (specify if yes):

___ Diabetes:
___ High Blood Pressure:
___ Heart Problems:
___ Lung Problems:
___ Thyroid Problems:
___ Kidney Problems:
___ Gallbladder Problems:
___ Bladder Problems:
___ Digestive Problems:
___ Rheumatoid Arthritis:
___ Hepatitis:
___ Cancer:
___ Recurrent Headaches:
___ Fainting:
___ Hearing/Vision Problems:
___ Other conditions:

Are you taking any medication? Yes No
Please list (including supplements) _____

Do You suffer from any Allergies? Yes No
Please list _____

List any Surgeries you have had (with date or age if possible)