Thriving Lives Co.

Empowering our community to live a life they love.

Please read and complete this form carefully.
This information will be kept confidential.

Personal Details

Title: Ms/Mrs/Miss/Mr/Master/other:

………………………………………………………………

Pronouns:

………………………………………………………………

Name:

………………………………………………………………

Address:

………………………………………………………………

Suburb:

………………………………………………………………

Post code:

………………………………………………………………

Sex *(please circle)*: Female/Male/Non-Binary/Intersex/Transgender/Prefer not to say/Another option………………………………

Phone number:

………………………………………………………………

Email Address:

………………………………………………………………

Date of Birth:

………………………………………………………………

Occupation:

………………………………………………………………

Guardian 1 Name (if applicable):

………………………………………………………………

Guardian 1 Contact Phone:

………………………………………………………………

Guardian 2 Name (if applicable)

………………………………………………………………

Guardian 2 Contact Phone:

………………………………………………………………

Next of Kin (if different to above):

………………………………………………………………

Next of Kin Contact Phone:

………………………………………………………………

Next of Kin (if different to above):

………………………………………………………………

Next of Kin Contact Phone:

………………………………………………………………

Emergency Contact:

………………………………………………………………

Emergency Contact Phone:

………………………………………………………………

How did you hear of us *(please circle)*:

Internet	Website	Friend/relative
Doctor	Facebook	Advertisement
Other:		

General Practitioners Details

GP's Name:

………………………………………………………………

Practice Name:

………………………………………………………………

………………………………………………………………

Address:………………………………………………………

………………………………………………………………

Phone:

………………………………………………………………

Fax:

………………………………………………………………

Health Fund/Services

Private Health Fund:

………………………………………………………………

Private Health Fund Number:

………………………………………………………………

Private Health Fund reference number:

………………………………………………………………

Medicare Number:

………………………………………………………………

Medicare Client Reference Number:

………………………………………………………………

Medicare Card Expiry:

………………………………………………………………

Claimant Name (if applicable):

………………………………………………………………

Claimant Medicare Number:

………………………………………………………………

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Claimant Medicare Client Reference Number:
……………………………………………......
Claimant Medicare card expiry:
………………………………………………
DVA File Number:
....
DVA Card Expiry:
....
DVA Card Type *(please circle)* : GOLD/WHITE
For white card holders, condition:
....
....
Are you covered by *(please circle)*:
Workcover Third Party Insurance Other
Claim Number:
....
Do you have a NDIS plan? Yes No
If yes, a NDIS referral form will be provided to your email address.

Health History
Injuries/conditions/operations:......................
....
....
....
Have you had any?
Blood tests ☐ *Xray* ☐ *Ultrasound* ☐ *CT* ☐
MRI ☐ *Operation* ☐
Details
....
....
Your goals (or 2 main reasons) for today's consultation?
………………………………………………
………………………………………………
………………………………………………
……………………………………………….

Please mark below any conditions that apply *(and if necessary, briefly explain)*			
High/Low Blood pressure	Heart Attack/ chest pain	Headache/ migraine	Stroke
Allergies/food intolerance	Osteoporosis/ osteopenia	Cancer	Pregnant
Asthma/Breathing difficulties	Dizziness/fainting/ Balance issues	Arthritis	Pacemaker
AIDS, HIV or Hepatitis	Artificial implants	Diabetes	Epilepsy
Pulmonary disorders	Peripheral vascular disease	Anemia	Other
Other details			
Family history of any of the above?			

Phone (07) 4065 8000
Fax (07) 3539 9821
Email info@thrivinglives.com.au
Address 208 Buchan St, Bungalow QLD 4870