Medical Questionnaire

This questionnaire does not provide advice. Nor does it substitute for advice from an appropriately qualified medical professional.

MOKSHA GUIDANCE PTY LIMITED (ACN 654 134 237) (we, us, our) requests that you complete this questionnaire to assist us in ascertaining if we are able to provide our services to you.

CLIENT DETAILS

Name:

Phone:

DOB:

Address:

Medicare No. and Name Shown on card:

EMERGENCY CONTACT DETAILS

Name:

Phone:

Email:

Relationship:

Do you have private health insurance?

- ❑ YES
- ❑ NO

If so, what is the name of your health fund and membership number?

Have you ever suffered or been told by a doctor that you have a mental health condition?

- ❑ YES
- ❑ NO

Has your doctor ever prescribed you medication for a mental health condition?

- ❑ YES
- ❑ NO

If you have been prescribed medication by a doctor, what was prescribed?

Are you receiving any other medical treatment at this time?

- ❑ YES
- ❑ NO

If so please provide details

Are there any additional comments or relevant information we need to be aware of?

You acknowledge that you have made us aware of any pre-existing conditions or other relevant personal circumstances that may affect the provision of our Services and warrant that you have answered all our medical questionnaires truthfully and accurately. You acknowledge that we will be relying on your disclosures in order to provide our Services.

Please see our full Terms and Conditions here and Waiver and Disclaimer here.

The information you provide is confidential and will be handled in accordance with our Privacy Policy.

Please also note that the information contained in this document will be copied electronically to your clinical record and any original afterwards destroyed. By signing this medical questionnaire you agree to have your information treated in the manner contemplated by this form, including consent to share such information with any third party health insurance provider (where applicable).

Signature

I believe to the best of my knowledge that all of the information I have provided on this medical questionnaire is accurate. If any of the above circumstances change, I will inform the Moksha Guidance by emailing silvana@mokshaguidance.com.

Signature:_____ Date: _____

Name: _____