Function.*allied* Health

REMEDIAL MASSAGE NEW CLIENT FORM

Today's Date: _____

Personal Details

Mr Mrs Miss Ms _____

Address: _____

Post Code: _____ Date of Birth: / / Number of Children: _____

Phone Number: (H) _____ (W) _____ Health Fund: _____

(M) _____ Email: _____

Occupation: _____ Partner's Name: _____

Outline any excercises or sports that you are currently participating in:

_____

_____

Referral Details

Who can we thank for referring you to us?

- ☐ Family/Friend: _____
- ☐ Health Fund
- ☐ Health Care Practitioner
- ☐ Signage/Drove past
- ☐ Social Media (Instagram)
- ☐ Social Media (Facebook)
- ☐ Website

Health Details

Please check-off any of the following that you suffer from/have suffered from.

- ☐ Spinal/Back problems
- ☐ Headaches
- ☐ Asmtha
- ☐ High/low blood pressure
- ☐ Osteoporosis
- ☐ Varicose Veins
- ☐ Cancer
- ☐ Surgery in Past 12 Months
- ☐ Bruising
- ☐ Allergies
- ☐ Heart Condition
- ☐ Joint Injury
- ☐ Arthritis
- ☐ Haemophilia
- ☐ Immune Deficiency
- ☐ Skin Disorder
- ☐ Numbness/Tingling
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Recent Bone Fracture
- ☐ Enlarged Lymph Nodes
- ☐ Thrombosis
- ☐ An Infectious Condition

Please list any other conditions not mentioned above that you would like to make us aware of.

_____

Please provide details of any other treatment you have had (i.e. physiotherapy).

_____

_____

Are you pregnant or is there a chance that you are pregnant?

- ☐ Yes How many weeks? _____
- ☐ No

Flip Over

What is the main reason you consulted this practice?

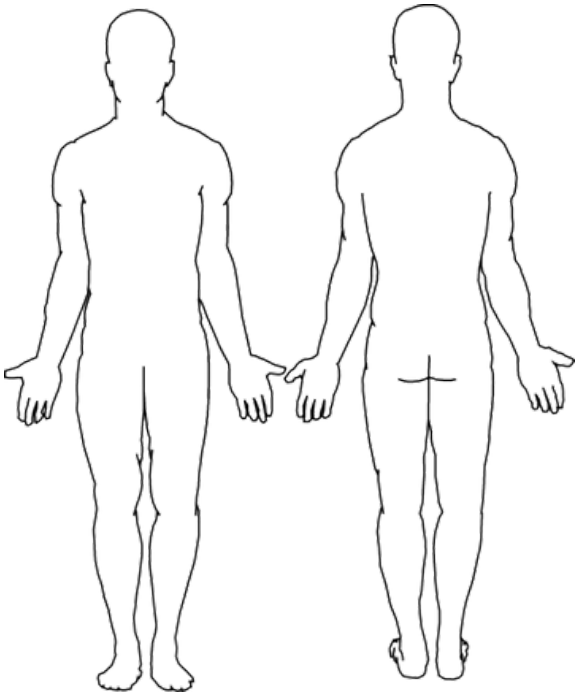
_____

_____

Please draw a circle around any areas of concern.

Remedial Massage may include *face, head, chest, stomach, back, buttocks, arms, legs, and feet* depending on the area of the problem.

Please use an X to indicate any area you *would not* like to have included in the massage.



Remedial Massage therapy is provided for stress reduction, relief from muscular tension, improvement in postural function, and improvement of circulation and energy flow.

Remedial Massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat, physical or mental illness. If you are in doubt, consult your medical practitioner.

I acknowledge that if I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I understand that Remedial Therapy involves deep soft-tissue work, and depending on the severity of the problem it is normal to feel some muscle soreness and tenderness within the days following the treatment.

I affirm that I have notified my therapist of all known medical history and I agree to inform the therapist of any changes in my health and any medical conditions.

Appointment Cancellation Policy

Please call us on 07 3351 0933 at least 24 hours prior to your scheduled appointment to notify us of any changes you need to make. To change a Monday appointment, please call our clinic by 12pm (noon) on Saturday. If prior notification is not given, you will be charged 50% of the cost of the visit for the missed appointment.

Client Name (PRINTED): _____

Client Signature (or Parent/Guardian): _____

Date: _____

Therapist Name (PRINTED): _____

Therapist Signature: _____

Date: _____

Please return this form to reception.