

CLIENT INFORMATION

Name:.....

Street Address:.....

Suburb:.....Post code:.....Birth Date:...../...../.....

Mob:.....Email:.....

Emergency Contact:.....Contact Number:.....

Do you give permission to receive updates via your email address? Y / N

If you receive Rebates for Remedial Massage which is your Health Fund?.....

How did you find out about my practice?.....

What is the main reason for your visit & the ideal outcome you would like to achieve?

.....

Work Activities:.....

.....

Sport & Recreational Activities & Frequency per week:

.....

Previous Injuries & Conditions:.....

.....

Are you suffering from any of the following? (please tick & give details next page)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> allergies | <input type="checkbox"/> dizziness | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> epilepsy | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> asthma |
| <input type="checkbox"/> rheumatism | <input type="checkbox"/> fluid retention | <input type="checkbox"/> blood disorder | <input type="checkbox"/> heart problems |
| <input type="checkbox"/> headaches | <input type="checkbox"/> spinal condition | <input type="checkbox"/> thyroid condition | <input type="checkbox"/> bursitis |
| <input type="checkbox"/> stress | <input type="checkbox"/> cancer | <input type="checkbox"/> insomnia | <input type="checkbox"/> infection |
| <input type="checkbox"/> tendonitis | <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> diabetes | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> cramps | <input type="checkbox"/> carpal tunnel | <input type="checkbox"/> kidney disorder | <input type="checkbox"/> r.s.i. |
| <input type="checkbox"/> skin conditions | <input type="checkbox"/> depression | <input type="checkbox"/> bone injuries | <input type="checkbox"/> fibromyalgia |
| <input type="checkbox"/> tinnitus | <input type="checkbox"/> heart problems | <input type="checkbox"/> stroke | <input type="checkbox"/> chronic pain |

Further details:.....

.....

Tricia Bartholomaeus _____ *Wholistic Remedial Massage*

Current Medication & Related Condition:.....

.....

Are you currently under the care of other Health Professionals? Eg: Chiro, Physio, GP

.....

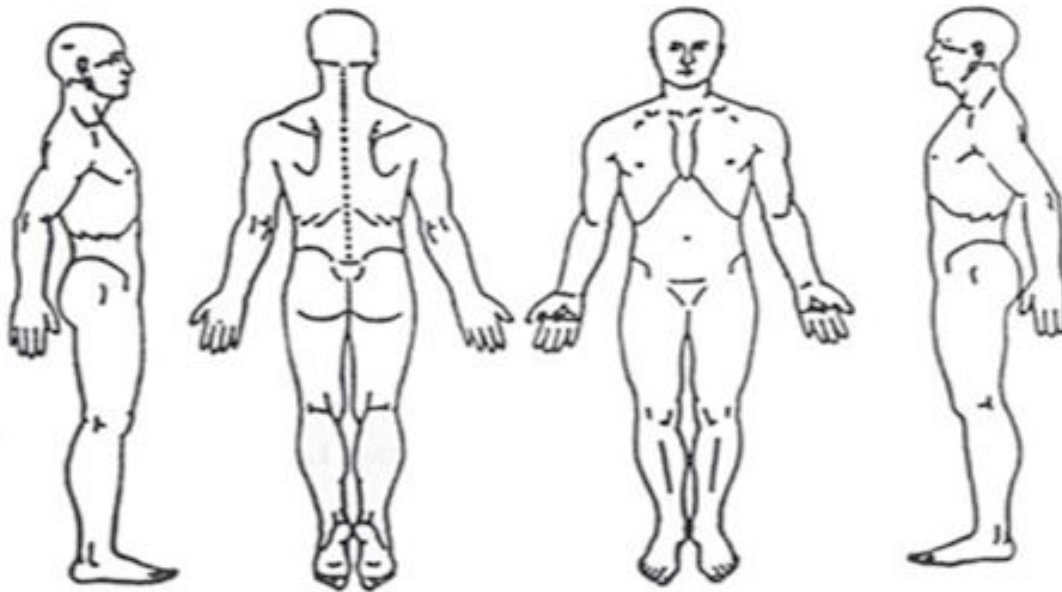
Are you allergic to massage or essential oils? Y / N Details.....

Women: Are you Pregnant? Y / N Weeks?.....

Is there any additional information you would like to provide relevant to your treatment?

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BODY MAP - Please circle areas of pain/tension that require attention:



*PLEASE BE ADVISED THAT 24 HOURS NOTICE IS REQUIRED TO RESCHEDULE/
CANCEL APPOINTMENTS OR FEES MAY BE CHARGED IF THE TIME CANNOT BE
FILLED FROM THE WAITING LIST*

Client Signature:.....Date:...../...../.....