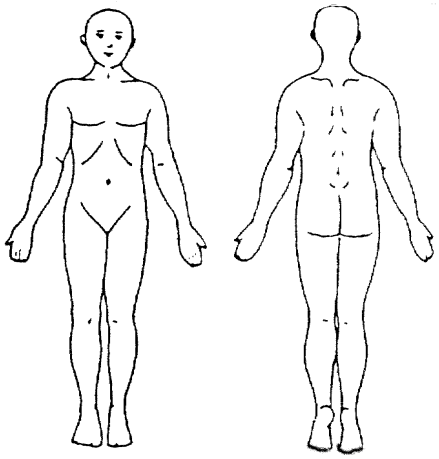
Welcome to our clinic

Please take a few minutes to complete this questionnaire so we may evaluate your condition thoroughly. When you have finished, please return it to your receptionist.

Name_____Date of Birth_____/_____/_____Age_____(yrs)
Address_____Suburb_____Postcode_____
Occupation_____☎(H)_____(W)_____(M)_____
Email Address (For newsletters & Special offers)_____
Marital Status_____Children(ages)_____Pregnant or Breast feeding?❑yes ❑no
Who referred you to this clinic? ❑Ms/Mr/Dr_____ ❑GP/Specialist
❑ Sign ❑ Website/Internet ❑ Your coach_____❑ Sports club/Association
Have you had previous Massage Therapy ? ❑yes ❑no Date of your last Massage?____/_____/_____
Techniques your Therapist Used: ❑Deep Tissue ❑Relaxation ❑Sports ❑Trigger Point Therapy
❑Other_____
Please describe your present complaint and illustrate the affected areas on the diagram:

_____
_____
_____

Indicate your areas of pain



Are there any other injuries/problems bothering you ?

_____
_____

Please list any illnesses you have

_____
_____

Please list any drugs, medicines or vitamins you take

_____
_____

Have you had any x-rays taken in the past five years ? If yes, please detail:_____

Please outline all sporting activities/training habits/hobbies and your level of participation

_____
_____

Please tick (✓) the corresponding box if you have suffered from any of the following:

❑ Anaemia	❑ Diabetes	❑ Thyroid disease/goiter	❑ H.I.V. / A.I.D.S.
❑ Rheumatic Fever	❑ T.B.	❑ Heart Disease	❑ Paralysis
❑ Asthma	❑ Kidney trouble	❑ High blood pressure	❑ Stroke
❑ Cancer / Tumors	❑ Epilepsy	❑ Psoriasis	❑ Ulcers
❑ Hepatitis	❑ Eczema	❑ Nervous breakdown	❑ Multiple sclerosis

It is customary to pay for all professional services when rendered. This centre does not send accounts. Payment for all services may be made by cash, cheque or Eftpos facility. We require a minimum of 24 hours notice for appointment rescheduling or a cancellation/non attendance fee will apply.

Client Signature_____Date_____/_____/_____