MASSAGE NEW PATIENT

Date: _______________

Personal Details

Title: _____ ____

Full Name

Address: ____

____ Post Code _________

Telephone: (Home) ________________ (Mobile) _______________________

(Work) ________________ (Email) ________________________

Date of Birth_____________ Number of Children: ___ Partners Name: _______________

Occupation:__________________________________ Health Fund: _______________

I am happy to receive Reminders Via- SMS Email Both

Referral Details

Who can we thank for referring you to us:

Family/Friend (name): _________________________________

☐ Social Media ☐ Google ☐ Signage ☐ Yellow pages

☐ Health Fund ☐ Health Care Practitioners ☐ Wellness Workshop ☐ Voucher

Health Details

Please Indicate if you do or have ever suffered from the following:

Spinal/Back problems
Headaches
Asthma
High/Low Blood Pressure
Osteoporosis
Varicose Veins
Cancer
Surgery in past 12 months

Bruising
Allergies
Heart Condition
Joint Injury
Arthritis
Hemophilia
Low Immunity
Skin Disorder

Numbness/ Tingling
Diabetes
Epilepsy
Recent bone Fracture
Enlarged Lymph Nodes
Thrombosis
An infectious condition

☐ Headaches	☐ Shortness of Breath	☐ Numbness in Arms/Hands
☐ Neck Pain/ Stiffness	☐ Loss of Smell	☐ Cold Hands/Feet
☐ Back Pain/ Stiffness	☐ Period Pain	☐ Cold Sweats
☐ Fatigue	☐ Constipation/ Diarrhoea	☐ Dizziness
☐ Depression	☐ Fainting	☐ Sleeping difficulty
☐ Fever	☐ Chest pain	☐ Can't fight infections

Which of the above is the reason you have consulted this practice: ___________________________________

What was the cause: ____

When did the problem commence: ____

Is the problem: Getting Worse Staying the Same Getting Better

Have you had a similar case before: Yes No

Does it interfere with: Sport Home Sleep Recreation Work

Have you previously seen a Massage Therapist:

Yes (Who) _________________________ Date:______________________ No

If yes was it for a similar condition: Yes No

Did it help: Not at all Some what Mostly Complete Resolution

Have you seen any other health professional about this problem:

Yes (Who) ________________________ Date: ______________________ No

Did it help: Not at all Some what Mostly Complete Resolution

Exercise/ Sports Activities

Please outline any exercises or sports that you are currently participating in:

____
____
____
____

Is there anything else you would like to tell us:

____
____
____
____

Springfield Lakes Chiropractic
Massage Clinic Consent Form

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

Please 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.

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.

____________________________	____________________________
Patient's Signature (Parent or Guardian)	Therapist's Signature
____________________________	____________________________
Patient's Name	Therapist's Name
__________________	__________________
Date	Date