MYOTHERAPY NEW PATIENT

Adult

Date: _____

Personal Details

Title: Mr _____ _____

Full Name

Address: _____

_____ Post Code _____

Telephone: (Home) _____(Mobile)_____

(Work) _____(Email) _____

Date of Birth:_____ Age:_____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 tick all current or past conditions that apply to you (C – Current and/or P – Past)

Symptoms	C	P
General Wellbeing		
Fatigue	☐	☐
Tension	☐	☐
Fog	☐	☐
Stress	☐	☐
Irritability	☐	☐
Nervousness	☐	☐
Sleep Problems	☐	☐
Fever	☐	☐
Sweats	☐	☐
Loss of Smell	☐	☐
Loss of Taste	☐	☐

Symptoms	C	P
Other		
Diabetes Mellitus	☐	☐
Cancer	☐	☐
Hepatitis B/C	☐	☐
HIV/AIDS	☐	☐
ADHD/Autism/Asperger's	☐	☐
Men Only		
Prostate Problem	☐	☐
Testicular Pain	☐	☐
Fertility Problem	☐	☐
Low/ Loss of Libido	☐	☐
Erectile Dysfunction	☐	☐

Symptoms	C	P
Women Only		
Difficult Menstruation	☐	☐
Breastfeeding	☐	☐
Menopause	☐	☐
Pregnancy	☐	☐
Premenstrual Syndrome	☐	☐
Painful Intercourse	☐	☐
Fertility Problems	☐	☐
Low/ Loss of Libido	☐	☐

Symptoms	C	P
Pain/Stiffness		
Neck/Jaw	☐	☐
Back	☐	☐
Shoulder Arm/hand	☐	☐
Leg	☐	☐
At Night	☐	☐
In Morning	☐	☐
Pins & Needles/Tingling		
Arm/Hands/Fingers	☐	☐
Legs/Feet/Toes	☐	☐
Other	☐	☐
Numbness		
Arms/Hands/Fingers	☐	☐
Legs/Feet/Toes	☐	☐
Other	☐	☐
Cold Extremities		
Hands	☐	☐
Leg/feet	☐	☐
Swelling of Extremities		
Arms/Hands	☐	☐
Legs/Feet	☐	☐
Balance		
Weakness/clumsiness	☐	☐
Loss of balance	☐	☐
Vertigo	☐	☐
Respiratory System		
Difficulty Breathing	☐	☐
Cough	☐	☐
Chronic Cough	☐	☐
Sinus Problem	☐	☐
Hay fever	☐	☐
Asthma	☐	☐
Chronic bronchitis	☐	☐

Symptoms	C	P
Digestive System		
Diarrhoea	☐	☐
Gastric Ulcers	☐	☐
Nausea/Anorexia	☐	☐
Constipation	☐	☐
Abdominal	☐	☐
Indigestion	☐	☐
Reflux	☐	☐
Renal System	☐	☐
Frequent urination	☐	☐
Poor urine stream	☐	☐
Feeling of incomplete emptying	☐	☐
Urinary Tract Pain	☐	☐
Incontinence	☐	☐
Interstitial Cystitis	☐	☐
Immune System		
Frequent Colds/Flu	☐	☐
Frequent UTIS	☐	☐
Chronic Fatigue	☐	☐
Fibromyalgia	☐	☐
IBD – Crohn's or UC	☐	☐
Multiple Sclerosis	☐	☐
Glandular Fever	☐	☐
Allergies	☐	☐
Heart & Circulatory		
Chest pain	☐	☐
Heart Problem	☐	☐
Pacemaker	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Varicose Veins	☐	☐
Blood Clots (DVT)	☐	☐
Stroke (CVA)	☐	☐

Symptoms	C	P
Skin		
Rashes	☐	☐
Itching	☐	☐
Wounds slow to heal	☐	☐
Urticarial/ Hives	☐	☐
Bruise easily	☐	☐
Dermatitis	☐	☐
Psoriasis	☐	☐
Eczema	☐	☐
Neurological System		
Confusion	☐	☐
Memory loss	☐	☐
Altered Alertness	☐	☐
Changes in vision	☐	☐
Muscle Cramps	☐	☐
Seizures	☐	☐
Body Fatigue	☐	☐
Muscles Weakness	☐	☐
Depression/Anxiety	☐	☐
Senses		
Headache	☐	☐
Dizzy/ light headed	☐	☐
Heavy headed	☐	☐
Fainting	☐	☐
Visual light sensitive	☐	☐
Blurred vision	☐	☐
Visual impairment	☐	☐
Tinnitus	☐	☐
Loss of Hearing	☐	☐
Speech Impairment	☐	☐
Other (list below)	☐	☐

Accidents or Injuries

List any recent and past surgeries/injuries/illnesses: _____

_____

_____

Springfield Lakes Chiropractic & Massage
Clinic Consent Form

Myotherapy includes the use of dry needling and joint mobilisations and when performed by a qualified Myotherapist has been found to be both an effective and safe form of care for many health conditions.

There are however, risks associated with any treatment no matter how small, that you need to be informed of and we ask that you read the following carefully:

- I understand there are very minimal risks resulting from treatment, such as but not limited to; muscle and joint soreness, soft tissue and nerve irritation or damage.

- I understand that there are risks associated with dry needling and in some extremely rare cases, dry needling treatment can cause pneumothorax.

- I understand that results are not guaranteed and that consent can be withdrawn at any time.

- I give consent, by signing below, to cover the entire course of treatment for my presenting complaint(s), and for any other future condition(s) for which I seek treatment from the below named Myotherapist.

- I have read, or have had read to me the above consent and I have also had an opportunity to ask questions about this content.

- I give consent for my Myotherapist to consult and transfer relevant clinical information to other therapists in the clinic and other therapists I may see from time to time.

- I am aware of Springfield Lakes Chiropractic and Massage's Cancellation policy. I must give 24hours notice of any appointment cancellation or I shall be charged in full for the visit.

_____
Patient's Signature (Parent or Guardian)

_____
Myotherapist's Signature

_____
Patient's Name

_____
Myotherapist's Name

_____
Date

_____
Date