Muscleworx Myotherapy and Massage

PATIENT DETAILS:

Name: _____

Date of Birth: _____/_____/_____

Address: _____ Postcode: _____

Telephone: (H)_____ (W)_____ (M)_____

Email: _____

Occupation:_____

EMERGENCY CONTACT:

Name: _____

Contact Number: _____

Private Health Insurance (Please circle): Yes / No If Yes, which fund? _____

How did you hear about the clinic? _____

DO YOU HAVE OR HAD IN THE PAST ANY OF THE FOLLOWING?

High/Low blood pressure	Y / N	Sinusitis	Y / N
Varicose Veins	Y / N	Ladies, Are you pregnant?	Y / N
Allergies	Y / N	Menstruation Problems	Y / N
Skin Disorders	Y / N	Asthma	Y / N
Heart/Circulatory disease	Y / N	Arthritis	Y / N
Migraines	Y / N	Dizziness	Y / N
Headaches	Y / N	Cancer	Y / N
Osteoporosis	Y / N	Diabetes	Y / N

Please state if you have any other medical conditions _____

_____

List current medications _____

_____

Please state any surgery you have had _____

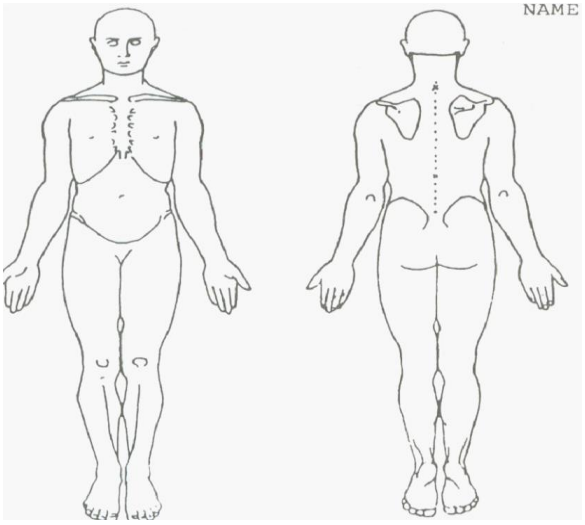
_____

Do you participate in regular exercise/ sporting activities? _____

_____

Is there anything else we should know? _____

Please explain your main symptoms/complaints and mark on the chart



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Signature: _____ Date: ____ / ____ / ____

(**Please note:** *There is a $25 dollar cancellation fee if 24 hours notification is not given)*