



MESSAGE

WELCOME TO HEALTHSPACE AND THANK YOU FOR CHOOSING US!

☐ MR ☐ MRS ☐ MS ☐ DR

FULL NAME

Date:

ADDRESS

PHONE: HOME

MOBILE

WORK

EMAIL ADDRESS

DATE OF BIRTH

OCCUPATION

MARITAL STATUS: M S W D

SPOUSE NAME

PREGNANT? Y / N

PRIVATE HEALTH FUND

Who can we thank for referring you to our HealthSpace?

REASON(S) FOR SEEKING MASSAGE THERAPY TREATMENT

- | | | |
|--|---|--|
| <input type="radio"/> Pain Relief | <input type="radio"/> Relaxation | <input type="radio"/> Referred by Chiropractor |
| <input type="radio"/> Muscular Injury | <input type="radio"/> Stress Reduction | <input type="radio"/> Referred by GP |
| <input type="radio"/> Concerned with posture | <input type="radio"/> Improve Wellbeing | <input type="radio"/> Other |

What is your main reason for massage treatment?

How long have you had this condition?

Have you had any other treatment for this? Y / N

If Yes, please specify

Have you received a medical diagnosis? Y / N

If Yes, please specify

List any activities that are painful to do or you can't do because of pain.

What medication or supplements do you currently take?

What injuries or surgeries have you had?

Do you participate in regular physical activities/sports? Y / N

If Yes, please specify

Give a brief outline of your diet

DO YOU HAVE ANY OF THE FOLLOWING? (Tick the appropriate box).

- | | | | |
|--------------------------------------|--|------------------------------------|---|
| <input type="radio"/> Headaches | <input type="radio"/> Pregnancy | <input type="radio"/> Diabetes | <input type="radio"/> Joint Replacement |
| <input type="radio"/> Whiplash | <input type="radio"/> Kidney Condition | <input type="radio"/> Osteoporosis | <input type="radio"/> Infectious conditions |
| <input type="radio"/> Skin Disorders | <input type="radio"/> Heart Condition | <input type="radio"/> Epilepsy | <input type="radio"/> Allergies |
| <input type="radio"/> Varicose Veins | <input type="radio"/> Chronic Pain | <input type="radio"/> Cancer | |

If ticked above, please specify:

Allergies

.....
Allergies to Essential Oils

.....
Infectious Conditions

.....
Skin Disorders

.....
Other

How would you rate your current health out of 10? **/10**

What is your goal health rating? **/10**

What are your desired outcomes for having massage care at ChiroSports?

Client Consent

I understand that the massage I receive at CHIROSPTS is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion and improve circulation. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medication and does not perform spinal manipulation. If I experience any pain or discomfort during the session, I will immediately inform the therapist so the treatment can be adjusted. I have informed the massage therapist of all my known physical conditions, medical conditions and medications. I will keep the massage therapist updated on any changes in my medical profile and I understand that there shall be no liability on the massage therapist's part should I fail to do so.

I understand that I need to give **24 hours** notice if I need to reschedule any future massages, so that this appointment can be offered to out waiting list. A late cancellation fee will apply if I do not give appropriate notice (50% of usual charge).

Client Signature Date