CLIENT RECORD

Private & Confidential

Private Health Fund? ☐ Yes ☐ No Fund..... Workcover/Claim No. .....

Surname..... Given Name/s.....

Address.....

..... State..... Postcode.....

Phone Home (.....) ..... Work (.....) ..... Mobile.....

Email .....

Date of Birth...../...../..... Marital Status.....

Children & Ages.....

Occupation.....

Recreation (Activities/Hobbies/Exercise).....

Current Doctor: Name..... Phone.....

Address.....

Referred by: Name..... Phone.....

Address.....

Are you currently being treated with another health care practitioner? ☐ Yes (please provide details) ☐ No

Name..... Phone.....

Address.....

MEDICAL HISTORY

Past Medical History (Surgery or Accidents - Year & Description).....

Medications (Prescribed or Natural).....

Presenting Symptoms.....

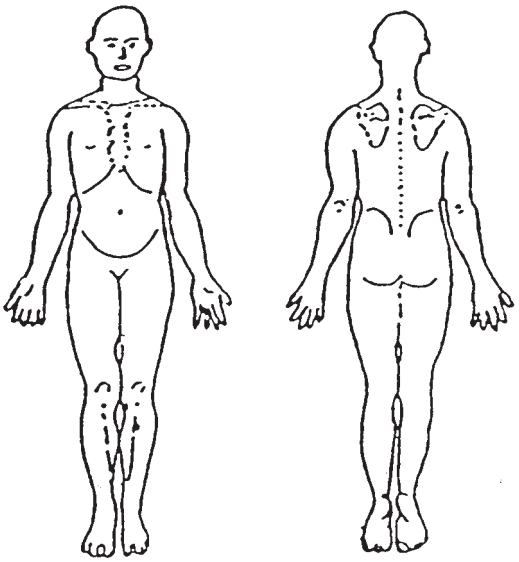
History of present problem .....

Description of Pain ☐ Dull ☐ Sharp/Acute ☐ Radiating ☐ Throbbing/Pulsating ☐ Other.....

Amount of Pain (1-10).....

What aggravates pain?..... What alleviates pain?.....

Please indicate areas of pain or soreness



Additional Information.....

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Please see over

MEDICAL HISTORY (continued)

Please tick (☑) all current conditions and mark past conditions with a **P**

☐ Allergies / Asthma	☐ Any contagious disease	☐ Headaches
☐ Cold / Flu	☐ Are you pregnant?	☐ Breastfeeding
☐ Any skin problem	☐ Spinal / Back problems / Injuries	☐ Pain / Stiffness
☐ Heart ailment	☐ Kidney ailment	☐ Diabetes
☐ Blood pressure	☐ Epilepsy	☐ Arthritis
☐ Blood clots	☐ Osteoporosis	☐ Chronic pain
☐ Respiratory / Asthma	☐ Recent illness / Surgery	☐ Numbness / Tingling
☐ Dizziness	☐ Joint replacement	☐ Cancer / Tumors
☐ TMJ syndrome	☐ Breast implant	☐ Varicose veins
☐ Car accident	☐ Recent fractures	
☐ Other (please list).....	☐	☐ .....

Past treatment or evaluation of the symptoms.....

.....

When, where and by whom?.....

.....

What studies have been performed in the past?.....

.....

What were the results?.....

.....

Results of past treatments.....

.....

Past diagnosis.....

.....

Contact in case of emergency Name.....

Phone.....

CLIENT DECLARATION

Consent is required for treatment.

The therapist has explained the intended treatment and I fully understand and consent to the prescribed method and treatment.

I hereby give permission to contact my primary health practitioner if required ☐ Yes ☐ No

Signature..... Date.....

Would you like to be on our mailing list? ☐ Yes ☐ No