

MASSAGE - CONFIDENTIAL CLIENT RECORD

Date:.....



Please complete this form as best as you can and return to the receptionist. Please print clearly.

Name:DOB: Occupation:

Home Address: Postcode.....

Work Ph: Home Ph: Mobile:

Do you have Private Health Insurance? No Yes Health Fund:

May we email you a monthly newsletter and occasional offers? No Yes

E-mail:

(We respect your privacy and will not submit your e-mail to any other party)

How did you hear about us?

- Walking past clinic
- Yellow/White Pages
- Yellow Pages On-line
- Gift voucher
- Advertisement/Flyer
- Web site
- Web advertising
- Other.....
- A friend told me (to enable us to thank them, please write their name)
- Referring health care practitioner (Name).....

Medical History:

Reason for your visit today?.....

Please tick (✓) all conditions that apply now. Write in P for past conditions.

- Unstable blood pressure
- Heart conditions
- Dizzy spells
- Respiratory complaints
- Epilepsy
- Long term stress
- Chronic headache
- Scoliosis
- Osteoporosis
- Immune system problems
- Whiplash
- Nervous system disorders
- Depression
- Panic/anxiety attacks
- Fractures/sprains/dislocations
- Skin conditions
- Diabetes
- Cancer treatment
- Undergoing IVF Treatment
- Thrombosis / Stroke
- Inflammation
- Implanon
- Contagious or infectious diseases
e.g. Hep. C (please give details)

Any other medical conditions? Please specify.....

Current medications, including aspirin, ibuprofen, herbs, vitamins, etc.....

Have you undergone surgery in the last 5 years? Please specify.....

For females : Are you pregnant? No Yes. If yes, how many weeks?

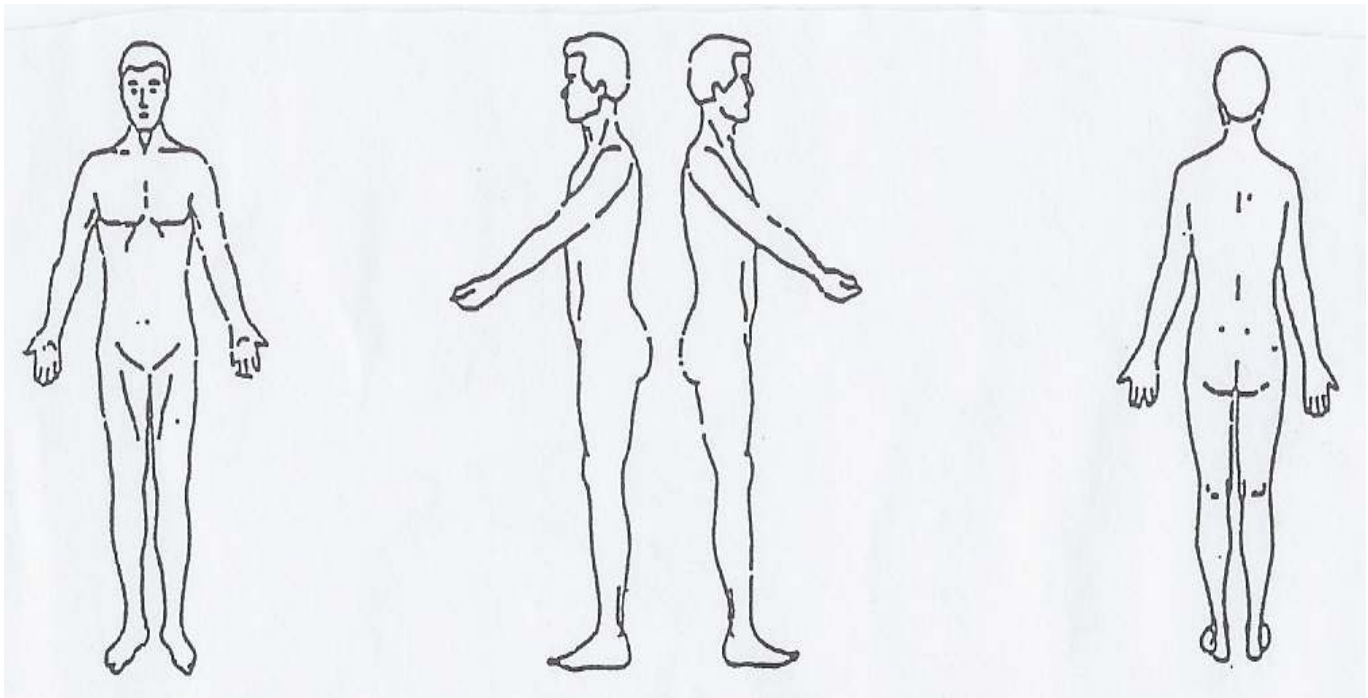
As a company policy we do not massage in the first trimester (up to 13 weeks) please talk to your therapist about other options.)

PLEASE NOTE: *If any of these conditions change, including pregnancy: please advise your therapist, so they may adapt your treatment accordingly. Ladies - before receiving abdominal massage you should advise your therapist if you are pregnant, menstruating or have an intrauterine device implanted.*

Your Massage Treatment:

- GO LIGHTLY: I just need to relax and want a gentle soothing massage.
- FIRM WHERE IT'S NEEDED, BUT LET ME RELAX: Please challenge my tight muscles and knots, but give me time to also relax.
- DEEP AND THERAPEUTIC: Please fix my problems by focusing on the tight areas. I'll let you know if it's too strong.

Indicate the area of pain on the diagrams below



On a Scale of 1 to 10 (10 being extremely painful), what is your current level of pain?

.....

How long has it felt like this?.....

Name of GP: Contact Number:

I (please print)..... declare that all answers and statements contained in this personal record, are true and complete. I understand that the therapist does not diagnose illness, disease or any other physical or mental disorder, does not prescribe medical treatment and does not perform spinal manipulations. It has been made very clear to me that massage therapy is not a substitute for medical diagnosis and treatment. I understand that the therapist must be aware of all past and present physical conditions, I have stated all known medical conditions and take it upon myself to keep the therapist updated on my physical health.

Clinic Structure Disclosure Statement

Chillout Enterprises Pty Ltd trading as Assiram Natural Therapies (the Company) is in the business of providing facilities to practitioners to carry out their professions as natural therapists. Each practitioner is an independent contractor of the Company and is not an employee. Each practitioner has taken out and is covered by malpractice insurance in that practitioner's name.

Cancellation Policy

We require 24 hours notice for all cancellations. If you are unable to make your appointment please phone us to reschedule. You may be charged for the cost of your treatment if you cancel without adequate notice.

I have read and understand this Disclosure Statement.

Signature

Date...../...../.....