

MUSCULOSKELETAL THERAPY — Confidential Client Record

Date:.....

Please complete this form and return to the receptionist. Please print clearly.

Name:DOB: Occupation:

Home Address:

Work Ph: Mobile: Home Ph:

May we email you promotional offers and health and well-being information? No Yes

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

Are you a member of a Private Health Insurance? No Yes Your Fund:

How did you hear about us?

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

Medical History:

Reason for your visit today?.....

Please tick (✓) all conditions that apply now or write P = for past.

- | | | |
|--|--|--|
| <input type="radio"/> Unstable Blood Pressure | <input type="radio"/> Neck pain | <input type="radio"/> Heart conditions |
| <input type="radio"/> Dizzy spells/fainting | <input type="radio"/> Shoulder/arm/hand pain | <input type="radio"/> Cancer treatment |
| <input type="radio"/> Respiratory complaints / COPD | <input type="radio"/> Chest/rib pain | <input type="radio"/> Epilepsy |
| <input type="radio"/> Headaches/Migraines | <input type="radio"/> Pelvic/abdominal pain | <input type="radio"/> Diabetes |
| <input type="radio"/> Depression | <input type="radio"/> Mid/lower back pain | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Long term stress | <input type="radio"/> Jaw pain | <input type="radio"/> Scoliosis |
| <input type="radio"/> Panic/Anxiety attacks | <input type="radio"/> Muscle twitching/cramps | <input type="radio"/> Arthritis/Rheumatism |
| <input type="radio"/> Nervous system disorders | <input type="radio"/> Hip / leg / knee / foot pain | <input type="radio"/> Thrombosis / Blood clots / History of Stroke |
| <input type="radio"/> Ringing in the ears (Tinnitus) | <input type="radio"/> Fractures/sprains/dislocations | <input type="radio"/> Numbness/pins & needles/tingling |
| <input type="radio"/> Immune system disorders | <input type="radio"/> Whiplash/ car accident | <input type="radio"/> Contagious or infectious diseases e.g. Hep C
(please give details)..... |
| <input type="radio"/> Skin conditions / Psoriasis | <input type="radio"/> Hypertension | |

Female client questions

Undergoing IVF treatment
 Implanon (implant)

Are you pregnant?

No
 Yes

If yes, how many weeks?.....

Other medical conditions? Please specify.....

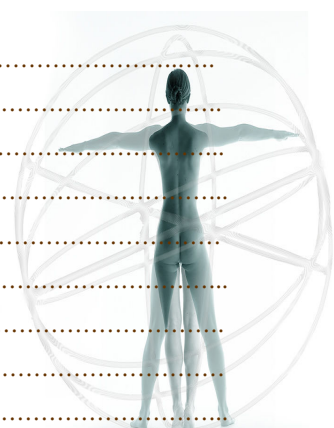
Have you undergone surgery in the last 5 years? Please specify.....

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

Any work related activities that cause or aggravate the problem?

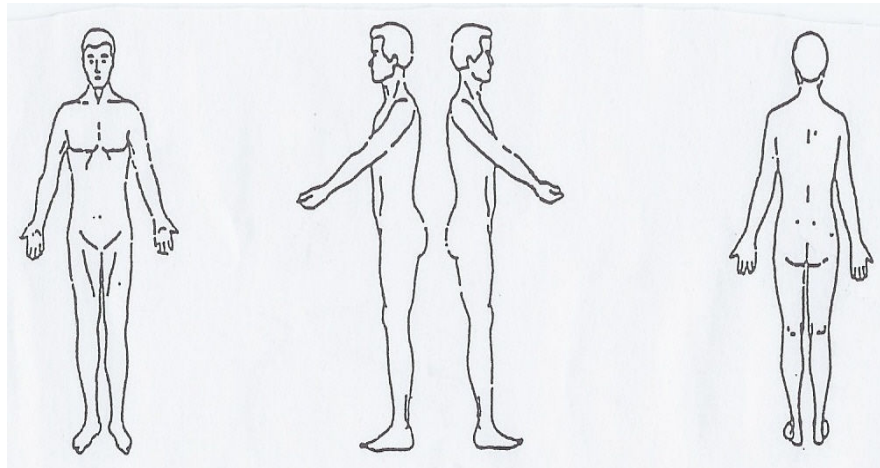
Sport/Exercise now or in the past.....

Any current / previous injuries? Please describe



Please turn over

Indicate the area of pain on the diagrams below:



What is your current level of pain on a scale of 1 to 10? (10 being extremely painful)

How would you describe the pain? Sharp Burning Dull Throbbing Pins & needles

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

Is the condition: Improving Not changing Getting worse Coming and going

What do you think caused this pain?.....

Is there anything that you find relieves this pain?.....

Is there anything that aggravates this pain?.....

Does this pain: Make it difficult to sleep Awaken you whilst sleeping

Name of GP: Contact number:

Please tick any treatment/s below that you have undertaken in the past to alleviate this pain:

(Please indicate N = Nil P = Poor F = Fair G = Good ST = Short Term LT = Long Term)

Physiotherapy..... Chiropractor..... Exercise..... Massage.....

Bed Rest..... Osteopath..... Acupuncture..... Other.....

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 intra-uterine device implanted.

I (print name)..... declare that all statements contained in this personal record are true and complete. I understand that the Musculoskeletal Therapist must be aware of all past and present conditions. I have stated all known medical conditions and take it upon myself to keep the Therapist updated on my physical health. I understand Musculoskeletal Therapy is not a substitute for medical diagnosis and treatment. I have been informed of the details of my treatment and consent to ancillary techniques such as myofascial dry needling and cupping therapy, if recommended by the Musculoskeletal Therapist.

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. Please sign

Signature.....

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