Remedial 360: Medical & Health History Form

Name: _____D.O. B.: _____
Address:_____
Mobile Phone._____ Home Phone: _____
Email:_____
Name & number in case of emergency:_____
Occupation:_____
How did you hear about us?_____
Private Health Fund: _____

Please tick (x) all the conditions that apply now and put a **P** for past conditions:

□ Heart, Circulatory Problems	□ Cancer/Tumours	□ Vision Problems
□ High/Low Blood Pressure	□ Asthma	□ Hearing Problems
□ Varicose Veins	□ Difficulty Breathing	□ Fatigue
□ Blood Clots	□ Hernias	□ Depression
□ Phlebitis	□ Digestive Problems	□ Seizures
□ Infectious Disease	□ Osteoarthritis/Rheumatoid	□ Stroke
□ Rash,/Tinea	□ Numbness/Tingling	□ Skin Disorders
□ Allergies	□ Muscle Injury/Pain	□ Pregnancy
□ Diabetes	□ Bone Injury/Pain	□ Headaches
□ Motor Vehicle Accident	□ Joint Injury/Pain	□ Migraines
□ Accident/Trauma	□ Chronic Pain	□ Broken Bones
□ Memory Loss/Confusion	□ Disc Problems	□ Prosthesis

Please, provide further details of any conditions you have indicated or others not in this list:

_____

_____

Other medical conditions not listed (past/present):_____

_____

Are you currently on any medications? Yes □ No □ Details:_____

_____

Recent surgeries: Yes □ None □ Details:_____

_____

Name of your primary health care provider (doctor):_____

I give permission for my Remedial Therapist to consult with my doctor regarding my health and treatment if required Yes □ No □

Have you had a Remedial Massage before? Yes □ No □

What are your current complaints of injuries?

_____

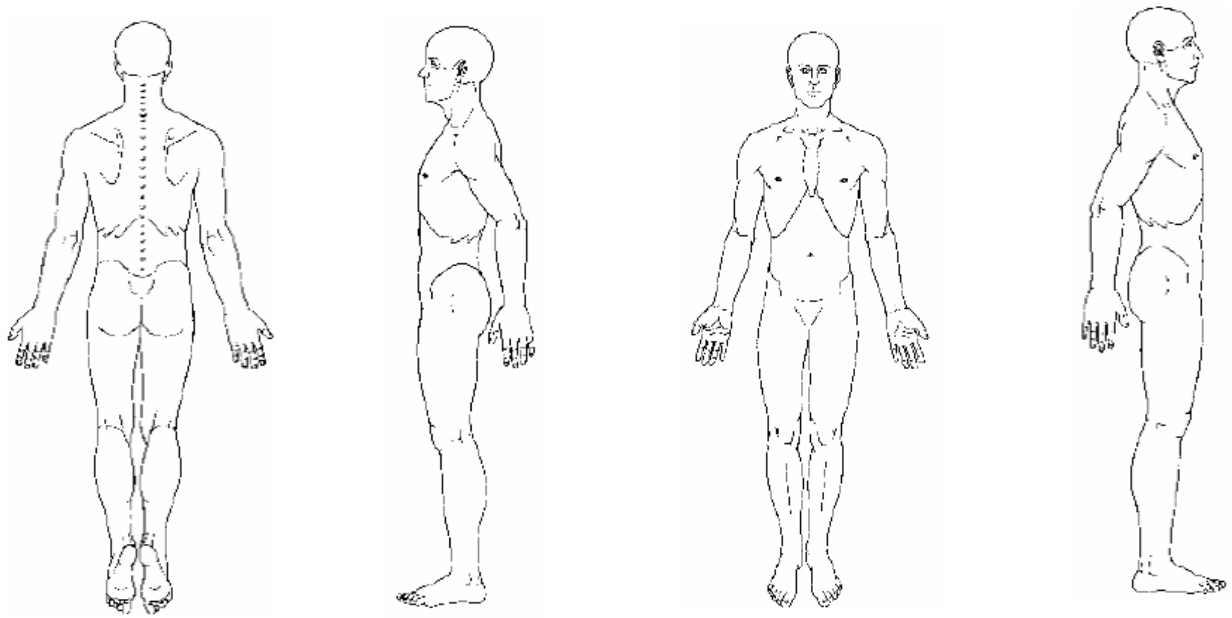
_____

_____

Which of the following best describe what you are experiencing?

Pain	□	Mild	□	Getting worse	□	Increase with activity	□
Ache	□	Moderate	□	Staying the same	□	Reduces with activity	□
Tension	□	Disabling	□	Getting better	□	No change	□
Discomfort	□	Constant	□	Imbalance	□	Intermittent	□

On the diagram below identify where your current symptoms are by circling the area and marking it with a:
P = Pain **S** = Muscle stiffness **JT** = Joint pain **N** = Numbness & tingling:



Notes:

_____

_____

_____

Important:
The remedial assessment and treatment procedures of 'Remedial Massage & Musculoskeletal Therapy' have been fully explained to me. I give full consent for the therapist to observe, palpate and treat each part of the body as required. It may be necessary to discuss my condition and treatment with my doctor. I have disclosed all relevant medical history, medications, and current symptoms prior to treatment.

I do not expect the therapist to have foreseen any previous or pre-existing condition that I have not mentioned. I understand that massage may provide benefits for certain conditions but results are not guaranteed. These benefits may include relief of muscular tension, relaxation, reduction in the symptoms of stress-related conditions and provision of general wellbeing. I also understand that massage therapy may produce side effects such as muscle soreness, mild bruising, increased awareness of areas of pain and light-headedness amongst other possible temporary outcomes. I am aware that the therapist does not diagnose illnesses, prescribe medications nor physically manipulate the spine or its immediate articulations.

The therapist understands that I have the right to question procedures used and to receive an explanation of any procedures that the therapist performs. I will tell the therapist about any discomfort I may experience during the therapy session and understand that the therapy will be adjusted accordingly. I confirm that I am not under the influence of alcohol or Illicit drugs today or on future visits.

Client Signature (or Guardian's) _____ Date _____

Privacy Policy This practice is committed to the privacy of its clients. Personal information is treated as confidential and is used only for the purpose for which it was collected. Information kept on file will not be released to a third party without the express consent of the client or as required by law.