FamilyHealthProfessionals
HELENSVALE
Southport Chiropractic CLINIC

Massage Therapy

New Patient History & Consent

Title: ________ Given Names: ____ DOB: _____________________

Address: ____

Phone: ___________________________________ Occupation: ____

Email Address: ____

Emergency Contact Name: _______________________ Relationship to You:__________ Number:_________________

Medical Doctors Name: _______________________________________ Contact Number: _________________________

How did you hear about us? Yellow Pages________ Google_______ Signage____________ Staff______________

Clinic Patient (please provide their name so we can thank them) ________________________ Other______________

Reason for this visit: ____

Recreational Activities: ____

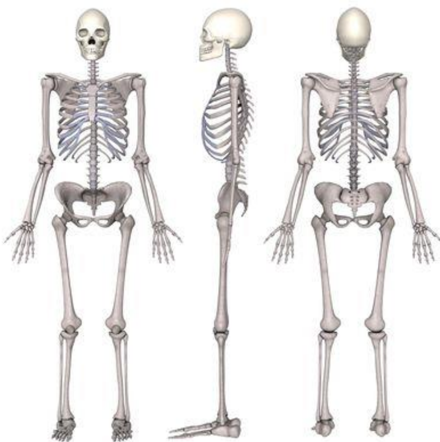
I am only interested in alleviating my pain Yes____ No____

I am interested in resolving the cause of my problem Yes____ No____

Have you received treatment for this in the past? Yes____ No____

Details of past treatment: ____

PLEASE INDICATE ANY AREAS OF CONCERN OR COMPLAINT ON THE DIAGRAM BELOW



Question	
Are you on any medication? (if yes please note below)	Y N
Have you had a motor vehicle accident or serious injury?	Y N
Have you been admitted to hospital in the past 12 months?	Y N
Do you have any xrays, CT scans, MRI, Ultrasound?	Y N
Do you have any ongoing health problems?	Y N
Have you had any unexplained weight loss?	Y N
Have you had any abnormal bleeding from any body part?	Y N
Have you had any recent changes in a mole or freckle?	Y N
Do you have any unusual lumps or swellings?	Y N
Have you ever or do you suffer from any of the following:	
Blood Clots or Stroke	Y N
High/Low blood pressure	Y N
Numbness or tingling	Y N
Osteoporosis	Y N
Skin conditions	Y N
Neck injuries / whiplash	Y N
Allergies	Y N
Headaches / migraines	Y N
Cancer	Y N

If you answered yes to any of the above please supply details here: _________________________________

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This form has been designed to assist with delivering the most appropriate chiropractic treatment and/or identifying any possible risk factors to your health and safety to provide appropriate care and advice.

Please note that any and all information, written or otherwise, that you give us is strictly confidential and is so treated by the entire staff. No information or records will be released to any person, health fund, insurance company or any doctor without the written permission of the patient.

We would like to include you on our email list so you receive our health updates and special offers, please check this box if you DO NOT wish to receive these emails. ☐

I believe the information above is correct to the best of my knowledge. (Please sign below)

Cancellations: We ask that you respect our cancellation policy to ensure we have enough time to contact other patients on our waiting list. 24 hours notice is required for cancellation or re-scheduling. If notice is not received, a cancellation fee may be charged.

I have informed the Massage Therapist of all of my known physical and medical conditions and medications and I understand that it is my responsibility to keep the Massage Therapist updated on any changes.

Patient Name: ___________________________________ Signed: _______________________ Date: ___________

Name of Parent /Guardian signing (if under 18 years): ____