Myotherapy Client History Form

In order to maximise the effectiveness and safety of your treatment, please take the time to carefully fill out this questionnaire. This information will be treated confidentially. **PLEASE PRINT CLEARLY.**

Referred by:____Date of initial visit:_____________

Title:_____Name & Surname:____D.O.B:_________

Address:____p/code:_________

PH (H):_______________________PH (W):______________________Mobile:________________

Email:____

Occupation:___________________________Sporting activities:_____________________________

Are you currently being treated by a health care practitioner? □ No - □ Yes What type?__________
For what condition?____

Reason for requesting a myotherapy treatment:____

Have you had any serious illness? □ No - □ Yes(please list):________________________________

____

Have your recently had any traumatic accidents or broken bones? □ No - □ Yes(please list):______

____

Have you had any operations or surgery? □ No - □ Yes(please list):__________________________

____

Are you on any medication? □ No - □ Yes(please list):____________________________________

Do you use supplements/vitamins? □ No - □ Yes(please list):_______________________________

Do you have Private Health cover? □ No - □ Yes(please list):_______________________________

: MEDICAL HISTORY:

Do your currently have, or have you recently had any of the following:

	Yes	No		Yes	No
Frequent or severe headaches	□	□	Epilepsy	□	□
PMT- Painful Periods	□	□	Eczema/ Psoriasis	□	□
Varicose veins, actual or suspected thrombosis or embolism	□	□	Diabetes	□	□
Skin rash/ skin sensitivity / allergies	□	□	Abdominal Pain	□	□
Easy bruising	□	□	Spinal Disc problems	□	□
Recent severe sprains or bruises (acute/subacute inflammation)	□	□	Insomnia	□	□
Infections or contagious diseases eg. Hepatitis, herpes, TB.	□	□	Numbness	□	□
Heart disease eg Angina	□	□	Rheumatoid arthritis	□	□
Conditions involving weakened bones eg. Osteoporosis	□	□	Osteoarthritis	□	□
Rapid loss or gain in weight	□	□	High Blood Pressure	□	□
Spinal problems causing abnormal sensation in the limbs	□	□	Cancer- Malignancy	□	□
Neck or spinal injury	□	□	HIV	□	□

Any undiagnosed severe pain or worsening conditions:_________________________________

Signed:____Date:______________