Massage Therapy Case History Form

Title: _____ First Name: _____ Last Name: _____ Preferred Name: _____

Date of Birth: _____ /_____ /_____ Address: _____

Phone: _____ Email: _____ Occupation: _____

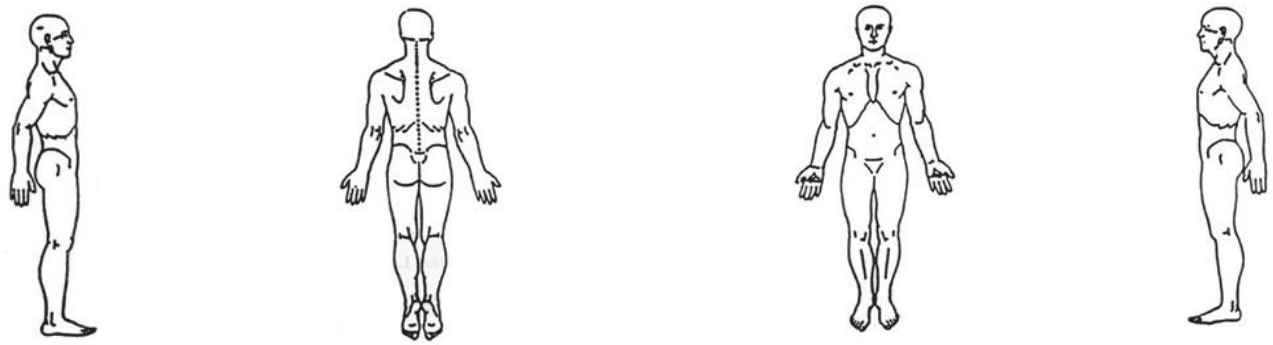
Are you in a Health Fund? _____ If yes, which one? _____ Concession? _____ Exp: ___ /____ /____

Previous Massage? _____ What is the main reason for your visit? _____

How did you find out about us/who recommended you?

☐ Google ☐ Social Media ☐ Friend/Family - Name: _____ ☐ Other

Please locate on the diagrams below: X for pain; O for stiffness; N for numbness



Please rate the pain on a scale of 0 (no pain) to 10 (extreme pain): _____

Any allergies? YES / NO If yes, what? _____

Any contact lenses, prosthetic devices, dentures or pacemaker? YES / NO Any chance of you being pregnant? YES / NO

Are you currently seeing a medical doctor, chiropractor, osteopath or any other health care practitioner? YES / NO

If yes, for what condition(s)? _____

Taking any medication? YES / NO What for? _____

Whilst massage therapy is very beneficial, it may sometimes not be appropriate, or it may need to be modified to best suit your needs and state of health. Please circle Yes or No to all the listed conditions listed below and if you currently have or had any of the following in the past, please provide details under Comments below:

		Comments			Comments
Headache	Y N		Indigestion	Y N	
Head Injury/Concussion	Y N		Nausea/Vomiting	Y N	
Seizures	Y N		Diarrhoea	Y N	
Vision Disturbance	Y N		Varicose Veins	Y N	
Ear Infection/Pain	Y N		Malnutrition/Weight Loss	Y N	
Inflammation	Y N		Infectious Diseases	Y N	
Any form of cancer	Y N		Skin Condition	Y N	
Chest Pain	Y N		Fracture(s)	Y N	
Breathing Problems	Y N		Diabetes	Y N	
Asthma	Y N		Sprain/bruises	Y N	
Tuberculosis	Y N		Fever	Y N	
Heart Problems	Y N		Tetanus	Y N	
High Blood Pressure	Y N		Any undiagnosed pain	Y N	
Back Pain	Y N		Past/Scheduled Surgery	Y N	
Should/Hip/Knee Pain	Y N		Other	Y N	

FINANCIAL POLICY: *We would appreciate payment at time of consultation.*

Cancellation Policy:

Tamar Chiropractic & Allied Health is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us by 5pm the business day prior to your scheduled appointment to notify us of any changes. Failure to do so incurs a fee equal to that of the booked appointment.

Patient's Signature…….. Date ……/……/…….

Do you authorise someone to make or change appointments on your behalf?

Nominated Person: …… Relationship: ……

Patient's Signature: ……

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