Move It CHIROPRACTIC
Our family caring for your family.

Confidential Massage Patient Information & History Form

Welcome to Move It Chiropractic. Please complete this form to the best of your ability & add any additional notes/information you feel would be beneficial for the Massage Therapist to know to assist you most effectively.

PATIENT INFORMATION

Today's Date: ____ / ____ / ____ First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ Age: _____

Mobile #: _____ Home #: _____ Work #: _____

Email: _____

Emergency Contact: _____ Contact Number: _____ Relationship: _____

Occupation: _____ Employer/School: _____

Home Address: _____

Suburb: _____ State: _____ Postcode: _____

Partner Name: _____ Children Names: _____

We appreciate referrals, who may we thank for referring you? ☐ Person (please specify) _____

☐ Online Search ☐ Website ☐ Facebook ☐ Signage ☐ Medical Practitioner ☐ Other _____

Private Health Fund: _____ Member Number: _____

Medicare Number: ☐☐☐☐ ☐☐☐☐☐ ☐ Medicare Ref Number (number beside your name): ☐

Do any of the following apply for this visit: ☐ Pensioner ☐ Workers Comp ☐ DVA ☐ ECP/Medicare

Have you had a massage before? ☐ No ☐ Yes (by whom) _____ (in what year) _____

Current Health Care professional: Doctor _____ Natural Therapist _____

HEALTH & MEDICAL HISTORY

Sporting & exercise programs: _____

Hobbies: _____

Accidents & injuries: _____

Operations: _____

Medications/supplements: _____

(Please indicate if you have had any of the following conditions)

Y	N		Y	N		Y	N	
☐	☐	Allergies/Asthma	☐	☐	Arthritis	☐	☐	Osteoporosis
☐	☐	Any contagious diseases	☐	☐	Heart Ailment	☐	☐	Varicose Veins
☐	☐	Headaches	☐	☐	Kidney Ailment	☐	☐	Bruising
☐	☐	Cold/and or flu	☐	☐	Numbness/Tingling	☐	☐	Recent injury/Surgery
☐	☐	Pregnant/breast feeding	☐	☐	Blood Pressure High/Low	☐	☐	Breast Implants
☐	☐	Diabetes	☐	☐	Epilepsy	☐	☐	Car Accident
☐	☐	Any Skin Problem	☐	☐	Cancer/Tumours	☐	☐	Joint Replacement
☐	☐	Spinal or Back injuries	☐	☐	Blood Clots	☐	☐	Recent Fractures

Details of the above conditions if any _____

HOW CAN WE HELP YOU?

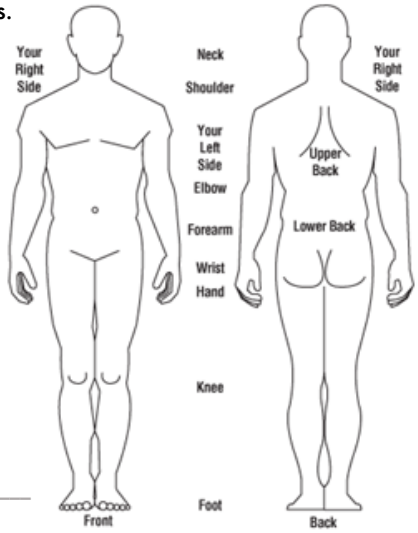
What do you want to achieve from your massage? _____

What are your symptoms? _____

Cause of Pain? _____ Have you had this condition before? (Please circle): Yes / No

What makes it worse? _____ What makes it better? _____

Location of pain? Please indicate on diagram below where you have pain or other symptoms.



What does it feel like? (please check where appropriate)

- ☐ Intermittent
- ☐ Dull
- ☐ Aching
- ☐ Tingling
- ☐ Burning
- ☐ Stiffness
- ☐ Cramping
- ☐ Nagging
- ☐ Constant
- ☐ Sharp
- ☐ Stabbing
- ☐ Shooting
- ☐ Throbbing
- ☐ Numbness
- ☐ Swelling
- ☐ Other

Any other problems you are concerned with:

_____

CLIENT DECLARATION – Please indicate below any areas you would prefer NOT to be massaged.

- ☐ Back
- ☐ Buttocks
- ☐ Legs
- ☐ Feet
- ☐ Arms
- ☐ Stomach
- ☐ Chest
- ☐ Face
- ☐ Head
- ☐ Shoulders
- ☐ Neck

1. I understand that I need to discuss with my therapist the side effects of massage treatments.
2. I also understand that the Massage Therapist does not diagnose illness, disease or any other physical or mental disorder, does not prescribe any medical treatment, & does not perform any spinal manipulations.
3. It has been made clear to me that Massage Therapy is not a substitute for medical diagnosis & treatment.
4. I understand that it is a recommendation to see a physician for any physical ailment that I might have.
5. I understand that my consent will be sought for the disclosure of any personal information prior to doing so.
6. A Massage Therapist must be aware of all past & present physical conditions therefore I take it upon myself to keep the Massage Therapist updated on my physical health.

PRIVACY STATEMENT – In accordance with the Privacy Act, all information relative to your case is held in total confidence. However, your consent is necessary to allow us to exchange information between Massage Therapists & other Practitioners within our clinic. When appropriate, relevant information regarding your case may be sent to other medical & healthcare practitioners for the proper & effective management of your condition.

CANCELLATION POLICY – We understand that unforeseen circumstances may arise, leading to the need to reschedule or cancel your massage appointment. However, to respect the time of our therapists & other clients, we have implemented the following cancellation policy:

- **Appointments cancelled on the day of the scheduled session or left unattended will incur a 50% cancellation fee.**

We appreciate your understanding & cooperation in adhering to this policy. If you have any questions or need to make changes to your appointment, please aim to contact us at least 24 hours in advance.

Today's Date: ____ /____ /_____ Print Full Name [patient]: _____

Patient's Signature: _____ Massage Therapist's Signature: _____
(or Parent/Guardian)