

DATE:

CONFIDENTIAL CLIENT INTAKE FORM

PERSONAL DETAILS:

NAME:

DOB: Age:

ADDRESS:

EMAIL:

PHONE:

NEXT OF KIN DETAILS:

NAME:

RELATIONSHIP: PHONE:

CONSENT TO CONTACT IN AN EMERGENCY: YES NO.

CHILDRENS NAMES AND AGES:

EMPLOYER AND OCCUPATION:

WORKCOVER CLIENTS: If Applicable

EMPLOYER:

CLAIM NUMBER:

REFERRING DOCTOR:

MANAGING AGENT DETAILS:

APPROVAL OBTAINED ON DATE: (MUST BE APPROVED PRIOR TO TREATMENT)

MEDICAL HISTORY: DO YOU EXPERIENCE ANY OF THE FOLLOWING?

<input type="checkbox"/>	Heart conditions	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	Motor Vehicle Accidents
<input type="checkbox"/>	High/low Blood pressure	<input type="checkbox"/>	Numbness or tingling	<input type="checkbox"/>	Surgeries
<input type="checkbox"/>	Cancer/Tumours	<input type="checkbox"/>	Chronic Pain syndromes	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	Muscle Injury	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	DVT/Varicose Veins	<input type="checkbox"/>	Bony Injury	<input type="checkbox"/>	Oedema
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Respiratory dysfunction
<input type="checkbox"/>	Head aches or Migraines	<input type="checkbox"/>	Immune disease	<input type="checkbox"/>	Infections
<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	Mental Health Conditions	<input type="checkbox"/>	

Please describe medical concerns further here:

Is there anything of concern that we have missed above?

Are you on any regular medications?

Do you have any allergies?

What is the purpose of your visit today?

How long have you had these symptoms or concerns?

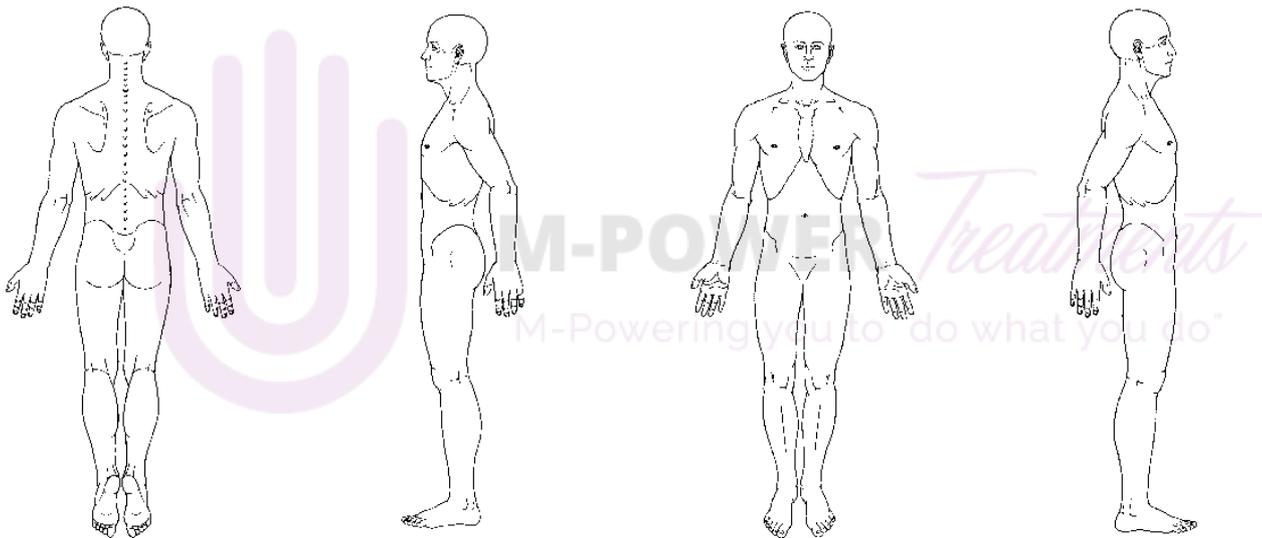
Do you have a diagnosis of your condition?

Is there any area of the body that you would not like to have treated? Feet, face.

How did you hear about us?

We have a referral policy so we would love to know if one of our clients has recommended us to you. Please leave details below.

PLEASE MARK ANY AREAS OF PAIN OR CONCERN.



INFORMED CONSENT:

I have completed the massage intake form to the best of my knowledge.

I will inform the therapist of any changes in my presentation and medical management.

Draping will be used during the session. Only the area being treated will be uncovered.

The massage therapist CANNOT DIAGNOSE any physical or mental health conditions.

Massage MUST NOT REPLACE MEDICAL CARE.

Massage can be used in conjunction with Primary Health Care. Eg General Practitioner/Osteopath.

It is my responsibility to consult a Physician for any concerns I may experience both on development of symptoms or on recommendation from my Myotherapist.

I understand that it may be contraindicated and not safe for massage to be performed with certain conditions on presentation. I am prepared to reschedule the massage and obtain a formal medical clearance at the request of my Myotherapist if required.

Clients under the age of 16 must be accompanied by a parent or legal guardian or care provider at all times.

I understand that I am responsible for payment at the time of consult.

I may also be liable for any late "cancellation" or "no show" fee if I fail to attend without proper notice in accordance with the Fees Policy.

NAME:

SIGNATURE:

DATE: