A: Shop 402, 326 Camden Valley Way, Narellan NSW 2567
A: Shop 1A/ 2-4 Main St, Mt Annan NSW 2567
P: (02) 4648 0022
E: admin@proactivespine.com.au
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proactive
spine & sports medicine

MASSAGE - NEW PATIENT FORM

Personal Details

Name: Dr/Mr/Mrs/Ms _____

Address: _____

_____ Postcode: _____

Phone Home: _____ Phone Mobile: _____

Email: _____ Occupation: _____

Date of Birth: _____ Age: _____

Marital Status: M / S / D / W No. of Children: _____

Emergency Contact Details: _____

How did you find out about us? _____

Do you belong to a Health Fund? Yes [ ] _____ No [ ]

Is this related to a Workers Compensation [ ] or Third Party Claim [ ] ? No [ ]

Who is your regular doctor (General Practitioner)? _____

Have you seen a Massage therapist before?

Yes [ ] Date of Last Massage _____

No [ ] Then don't worry! We will explain everything as we go and only proceed once you are completely comfortable.

Major Concern

What is your main problem/concern? _____

When and how did it start? _____

Is it Getting Better / Worse / Same ? (Circle one)

What makes it better? _____

What makes it worse? _____

Does the pain travel down your arms or legs? Yes / No _____

Have you had any other treatment for your current problem? Yes / No _____

_____

Previous Medical History

Do you have, or have you ever had, a serious health problem such as hypertension, heart disease, diabetes or any form of cancer? Yes / No _____

_____

Have you had any form of surgery? Yes / No _____

_____

Are you currently taking any form of medication? Yes / No If yes list all of them _____

_____

Have you had any broken bones? Yes / No If yes, which ones and how? _____

_____

Have you had any major accidents or falls? Yes / No If yes, when and describe _____

_____

Have any of your family members suffered from any serious or hereditary diseases? (e.g. cancer, diabetes, heart disease or any other major health problem) Yes / No _____

_____

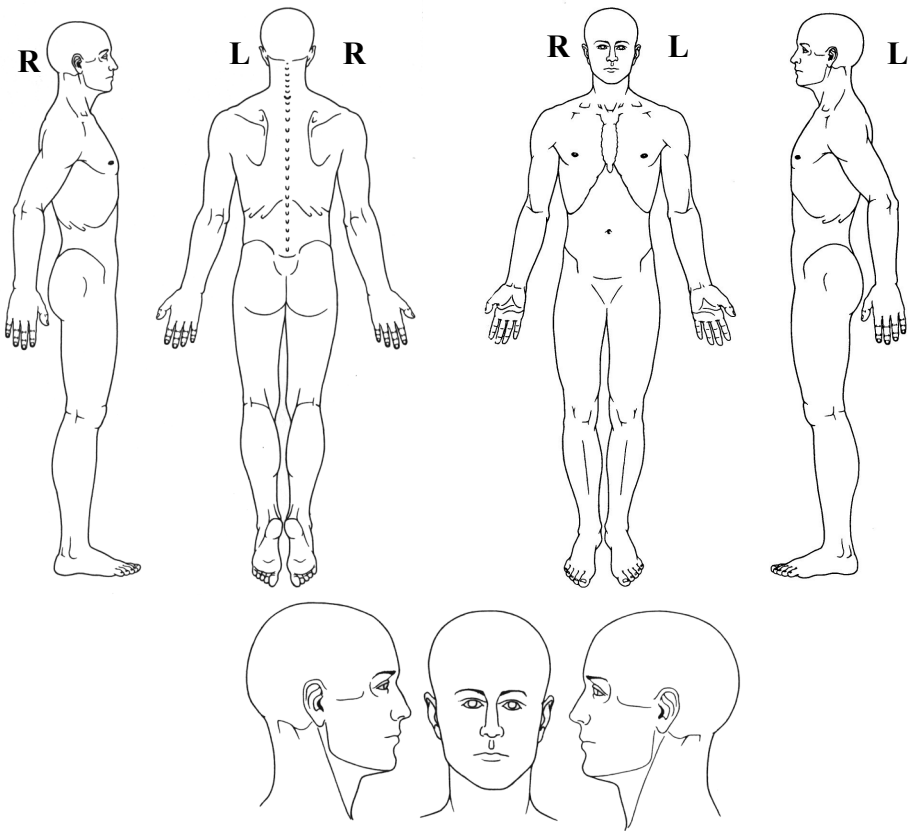
Do you suffer with any of the following? (please tick)

Dizziness [ ] Unexplained Weight Loss [ ] Loss of Bowel/Bladder Control [ ] Night Sweats [ ]
Headaches[ ] Recent history of cancer [ ] Sudden loss of consciousness [ ] Visual Changes [ ]

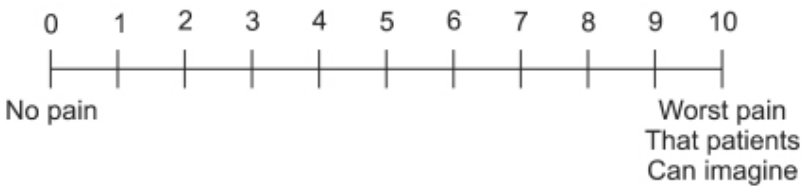
Do you (please tick)

Smoke [ ] Consume Excessive Alcohol [ ] Use Recreational Drugs [ ]

Please mark on the diagrams below any areas of discomfort or concern



Please mark on the scale what you would rate your pain?



Do You Have any Questions or Concerns? _____

_____

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CONSENT TO MASSAGE THERAPY

I, _____(Client's Name) have chosen to consult with and hereby give consent for massage therapy to be provided by **the below mentioned therapist** and/ or any other therapist working at **Proactive Spine & Sports Medicine** who I understand are members of the Association of Massage Therapists Ltd (AMT) and Australian Traditional Medicine Society (ATMS).

I have provided a detailed medical history. I do not expect the therapist to have foreseen any previous or pre-existing condition that I have not mentioned.

I understand that massage may provide benefits for certain conditions but results are not guaranteed. These benefits may include relief of muscular tension, relaxation, reduction in the symptoms of stress-related conditions and provision of general wellbeing.

I also understand that massage therapy may produce side effects such as muscle soreness, mild bruising, increased awareness of areas of pain and light-headedness amongst other possible temporary outcomes.

I am aware that the therapist does not diagnose illnesses, prescribe medications nor physically manipulate the spine or its immediate articulations.

The therapist understands that I have the right to question procedures used and to receive an explanation of any procedures that the therapist performs.

I will tell the therapist about any discomfort I may experience during the therapy session and understand that the therapy will be adjusted accordingly.

We understand that you may need to cancel your appointment occasionally. Please note that cancelations require at least 6 hours notice prior to your appointment. Please be advised that if a 6 hour cancellation notice is not met, or you have not shown up to an appointment you may be required to pay a cancellation fee of 50% before your next appointment.

Client Signature (or Guardian's): _____

Therapist's Name: _____Signature: _____

Dated _____

Privacy Policy
This practice is committed to the privacy of its clients. Personal information is treated as confidential and is used only for the purpose for which it was collected.
Information kept on file will not be released to a third party without the express consent of the client or as required by law.