CONFIDENTIAL CLIENT INTAKE FORM

The information you provide, will enable me to work with you in the most effective manner possible

jmc REMEDIAL MASSAGE

FIRST NAME | SURNAME

D.O.B | SEX | OCCUPATION

ADDRESS | SUBURB

STATE | POSTCODE | HOME PHONE

MOBILE | EMAIL ADDRESS

EMERGENCY CONTACT | EMERGENCY PHONE NUMBER

HOW DID YOU HEAR ABOUT US?

ARE YOU IN A HEALTH FUND? | IF YES, WHICH ONE?

ARE YOU CURRENTLY SEEING A HEALTH PROFESSIONAL? | PHYSIO | CHIRO | OT | GP | OTHER

HAVE YOU HAD A REMEDIAL MASSAGE BEFORE? | WHAT PRESSURE DO YOU PREFER?

ARE YOU TAKING ANY MEDICATIONS? | IF YES, WHAT ARE THEY FOR?

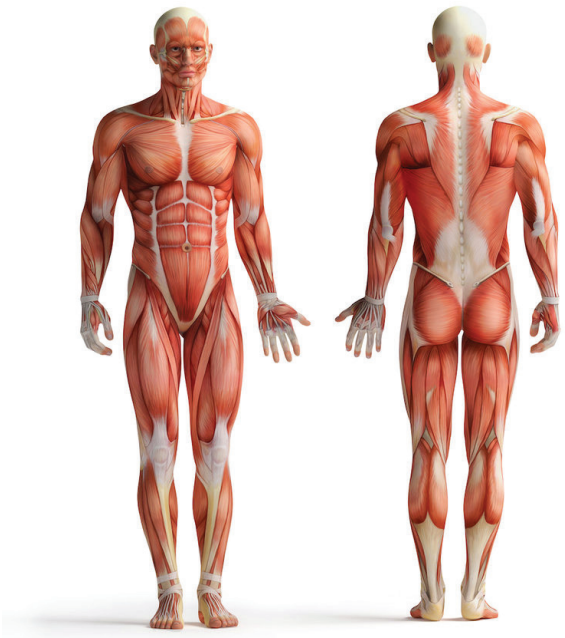
PLEASE MARK ANY OF THE FOLLOWING CONDITIONS OR SYMPTOMS THAT MAY APPLY TO YOU:

- ☐ HEADACHES / MIGRAINES
- ☐ DIZZINESS
- ☐ NECK PAIN
- ☐ BACK PAIN
- ☐ SHOULDER PAIN
- ☐ SCIATICA
- ☐ LEGS (HIP, KNEE, ANKLE, FOOT PAIN)
- ☐ ARMS (ELBOW, WRIST, HAND PAIN)

- ☐ BLOOD PRESSURE - HIGH \ LOW
- ☐ HEART PROBLEMS
- ☐ VARICOSE VEINS
- ☐ BLOOD CLOTS
- ☐ ALLERGIES
- ☐ CANCER
- ☐ INFECTIOUS CONDITION

- ☐ PREGNANT
- ☐ CAR ACCIDENT
- ☐ FALLS
- ☐ SURGERY
- ☐ ARTHRITIS
- ☐ OSTEOPOROSIS
- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ OTHER

PLEASE MARK ANY AREAS OF SORENESS



I understand that 12 hours notice is required to cancel or change an appointment otherwise fees may apply. If I experience any pain or discomfort during this session I will immediately inform the practitioner so that the pressure may be adjusted to my level of comfort. The above information is complete and accurate to the best of my knowledge. I agree to release the information for legal or medical purposes. I agree to pay for these services at the time of treatment.

SIGNATURE | DATE