ANDERSON FAMILY
CHIROPRACTIC
Health Centre

Massage Health History Form

Date: _____

Full Legal Name: _____

Preferred Name: _____ D.O.B: _____

Postal Address: _____

Suburb: _____ Post Code: _____

Home Phone #: _____ Mobile # : _____

Email address: _____

Occupation: _____

Do you have a **government-issued concession card**? _____

Are you a member of **a heath fund**? If so, which one? _____

Emergency contact Name: _____ Phone: _____

The biggest compliment to our clinic is the referral of your Family & Friends. **If you heard about us from a person**, please fill in their name so we can show them our appreciation:

If it wasn't from a person, how did you hear about us? _____

Have you received a professional massage before? _____

If under 18, please provide your Parent/Guardian's **name & mobile:**

Parent/Guardian 1: _____

Parent/Guardian 2: _____

Who to Contact Regarding Appointments: Please Select

Section 1: *In this section we aim to find out as much as we can about you so we can evaluate the best treatment methods tailored to your needs.*

Your Primary Symptom/Complaint: _____

_____

Any other secondary complaints?: _____

_____

Do you know how the main problem started? _____

_____

When did you first notice this problem? _____

What makes this problem feel worse? _____

_____

What have you tried to help relieve this complaint? Please indicate if you had relief from any of these: _____

How does this problem interfere with your daily life? For example, unable to sleep, cannot do usual hobbies, can't perform work duties, etc: _____

_____

What is the pattern of this problem?

◯ Constant ◯ On & Off ◯ Occasional ◯ Cyclical

What type of pain is it?

☐ Sharp ☐ Dull ☐ Burning/Stinging ☐ Pulsating

Does this pain travel to other parts of your body? If so, where? _____

_____

If relevant, are you pregnant? If so, how far along? _____

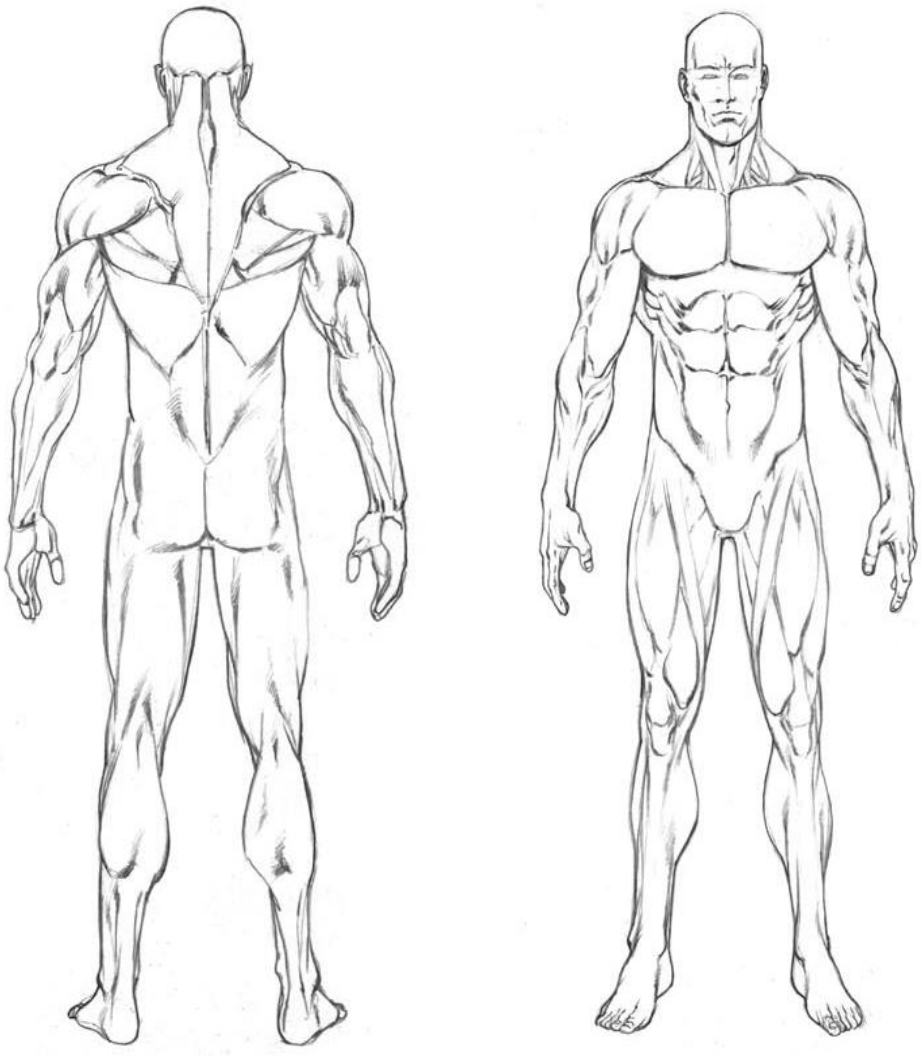
Do you have any concerns or additional information to let us know? _____

_____

Please list which areas you would like to have focused on:

_____

_____



Section 2: *In this section we ask questions that look at the body from a broader scope.*

Do you experience any of these conditions?

☐ Sensitivity to light	☐ Headaches	☐ Cold feet/hands
☐ Neck discomfort	☐ Fainting	☐ Reduced Flexibility
☐ Loss of balance	☐ Fatigue	☐ Pins and needles
☐ Tension	☐ Chest tightness	☐ Numbness in legs
☐ Numbness in arms	☐ Depression	☐ Dizziness
☐ Constipation	☐ Diarrhoea	☐ Anxiety
☐ Low blood pressure	☐ Migraines	☐ High blood pressure
☐ Heart Disease	☐ Diabetes	☐ Cancer

Have you suffered from any **major illnesses** or **accidents**? Please list and include **when they occurred** and **if it required hospitalisation**: _____

_____

Do you currently take any **medications** or **supplements**? Please list them including **dosage** and **purpose**: _____

_____

Do you have any **allergies? Please list:** _____

Do you smoke/vape? _____ How regularly do you consume alcohol? _____

If you are booked for a Remedial Massage and you fail to attend that appointment or if you cancel or reschedule with very short notice, we may ask you to pay the fee for your appointment. This amount will not be claimable through your private health fund, if you have one.

By signing, you agree that the information listed in the form is correct and has been filled out to the best of your ability. You consent to the treatment you are about to receive and will raise any concerns or questions with the therapist, also acknowledging that you or the therapist has the right to stop the treatment at any time.

Date: _____

Signature of Client: _____

Signature of Legal Guardian (if applicable): _____