Body Balance Wellness & Massage

Therapeutic Remedial Trigger Point Therapy Myofascial release

Date: 2.9.14

Personal Details

Your personal information is kept strictly confidential and only used for the purpose of treating you for massage.

Name: Dr / Mr / (Mrs) / Miss / Ms Allison Murray

Address: 50 Wade St Crookwell

Phone (H): 02 48320422 (W) _____ (M) 0427320422

Birthdate: 18.11.1980 Occupation: home duties Email: a.s.murray2@bigpond.com

Do you belong to a Health Fund (Please name)? Bupa Are you covered for Massage Therapy? (Yes) / No

List hobbies, sporting activities or exercise. _____

_____

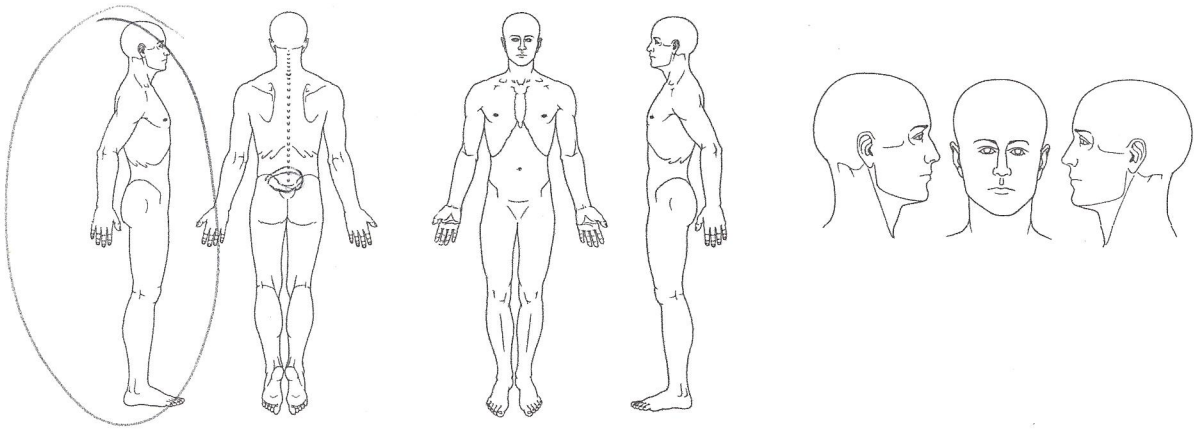
I am grateful that my business grows by referral. Were you referred by anyone?

(Friend) Family Yellow Pages Doctor Other (Please specify)? _____

Have you seen a Massage Therapist before? (Yes) No

Area of Discomfort or Concern

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



When did you first notice the problem? _____

What were you doing? _____

Have you experienced these or similar symptoms previously?

☐ No ☐ Yes (please describe) _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Please describe the sensation? _____
(eg. Tingling, aching, annoying etc.)

Have you done anything to address this problem? _____
(eg. See your GP, medication, Chiropractic etc.)

Do your symptoms disrupt any of your daily duties? _____

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Medical History

Do you have or have you had:

A serious injury (MVA, sporting, fall, accident)	Yes / (No)	
Spinal Disorder	(Yes) / No	Ruptured Disk L4-5
Recent surgery	Yes / (No)	
Broken bones	Yes / (No)	
Circulation problems	Yes / (No)	
Breathing difficulties	Yes / (No)	
Digestive problems	Yes / (No)	
Infections or contagious diseases	Yes / (No)	
Blood disorders	Yes / (No)	
Heart problems	Yes / (No)	
Allergies (particularly nuts/oils)	Yes / (No)	
Sleep disorders	Yes / (No)	
Asthma	Yes / (No)	
Headaches	Yes / (No)	
Blood pressure (please circle)	Low	(Normal) High

Are you currently taking any medication (please list): Lovan 20mg

Are you having treatment for any injury or ailment at present? _____

Are you pregnant? Yes / (No)

What do you hope to gain from your massage today? destress :)

In line with privacy laws you must give your consent if we are to contact you by mail. Please indicate your preference.
(I DO) / DO NOT consent to be contacted by mail with information relevant to my care.

Fees are to be paid on the day of service, unless prior arrangements are made

Name: Allison murray Signed: Allison murray

Date: 2.9.14

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Practitioner Notes

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