

## Feel Better Remedial Massage

### Personal information

First name POLI Last name CARIPIDIS  
Mobile number 0421 859 031 Email \_\_\_\_\_  
Date of birth 20 / 09 / 1981  
Address 11 MACK ST  
Postcode 4122 Occupation CONSTRUCTION

### Emergency contact

First name ELLEN Last name \_\_\_\_\_  
Mobile number 0452 615 552 Relationship WIFE

### Health History

If you have a history of any of the following conditions, please check below.

- ☐ Heart Conditions   ☐ Diabetes   ☐ Asthma   ☐ Headaches/Migraines   ☐ Dizziness  
☐ Pregnant   ☐ High Blood Pressure   ☐ Allergies   ☐ Cancer   ☐ Joint Replacement  
☐ Loss of Balance   ☐ Numbness   ☐ Recent Accident/Injury   ☐ Shingles  
☐ Sleep Disorders   ☐ Blood Clots   ☐ Depression/Anxiety   ☐ Infectious Conditions  
☐ Kidney Conditions   ☐ Neck/Spinal Injury   ☐ Skin Disorders   ☐ Varicose Veins

### Health History Details

If you checked to any of the above questions, please provide further information here.

N/A  
Surgeries N/A

### Current complaint

What is the reason for your visit? LOWER BACK PAIN

When did the problem begin? \_\_\_\_\_

Have you consulted any other health professionals about this problem? If so, please provide details.

\_\_\_\_\_

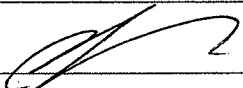
### Treatment consent

I have to the best of my knowledge, provided all relevant information about my health and medical history and I give my full consent to treatment. I intend this consent to apply to all future treatments and I understand that I must update my service provider with any changes that may occur in my medical history. I understand that a 50% cancellation fee may apply if I do not provide at least 24 hours notice.

☒ I consent to treatment

☐ I consent to receiving SMS and/or email for booking confirmation

Full Name ROLI CARIBIDIS

Signature  Date 18/07/2024

**If you are under the age of 18**, your parent/guardian must also sign and date your new client form.

☐ Yes, I'm the parent/guardian. Full Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_