Feel Better Remedial Massage

Personal information

First name Karen Last name Creed

Mobile number 0432030647 Email kjcreed1980@gmail.com

Date of birth 31/12/80

Address 64 Langden st, Coopers Plains, 4108

Postcode 4108 Occupation Education

Emergency contact

First name Adam Last name Creed

Mobile number 0430100228 Relationship Husband

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.

Sometimes IBS, Stomach Pains, Constipation regularly

Surgeries

Current complaint

What is the reason for your visit? stress, relaxation, tight muscles. I workout

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 Karen Creed

Signature _____ Date 03/02/25

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 _____

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CUPPING THERAPY CONSENT FORM

Have you had cupping treatment before? ☑ Yes ☐ No

I (client's full name) Karen Creed declare that the cupping therapy practitioner has fully explained to me the cupping therapy procedure, benefits, contraindications and possible side effects. I have been made aware that cupping marks may last between 1 to 3 weeks.

Signature _____ Date 03 / 01 / 25