



A GOOD THERAPIST

Personal Details

Name: Shivonne Annette Address: 7 Varadero Rd
Phone: (Home) _____ (Mobile): 0487130334 Email: Shivonne.marie88@gmail.com
Date of Birth: 29/4/88
If doing Astrology reading - Do you know the time of your birth? _____ Location: _____
Occupation: Mum Hobbies: _____
Next of Kin/Emergency Contact (Full Name): Darren Phone/Email: 0437587540
What is your private health fund? Medibank

Health Details:

- Reason for Treatment (relaxation, sports injury, muscle soreness etc.): Everywhere.
Medication in use (for example, steroids, HRT etc.): _____
- Are you Pregnant? If Yes please inform due date _____
- Health Conditions/Symptoms – please mark in the Past or Current section with a X

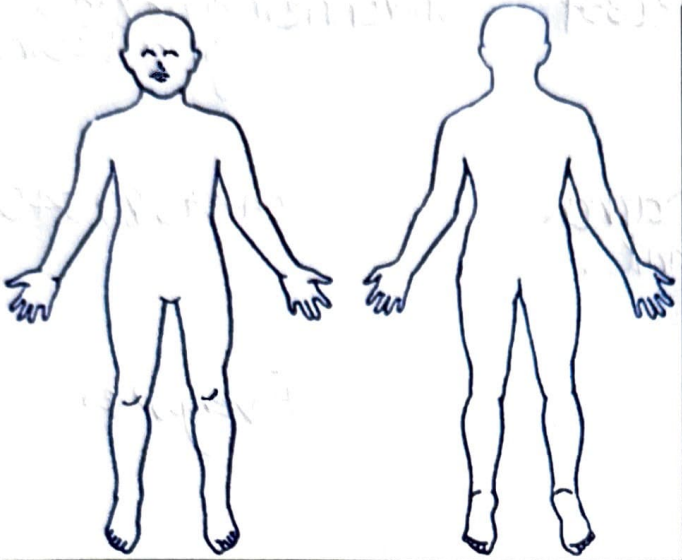
Condition/Symptoms	Past	Current	Condition/Symptoms	Past	Current
High/low Blood Pressure			Contagious skin conditions		
Cancer			Varicose Veins		
Respiratory Conditions			Allergies (please specify)		
Heart Conditions			Menstruation Problems		
High Cholesterol			Infertility		
Thyroid			Hormonal Problems		
Thrombosis/Phlebitis			Fluid Retention		<input checked="" type="checkbox"/>
Digestive Problems			Depression		<input checked="" type="checkbox"/>
Kidney/Bladder			Insomnia		
Epilepsy			Migranes		
Arthritis (Osteoarthritis)			Back or neck aches		<input checked="" type="checkbox"/>
Rheumatoid Arthritis			Other (please specify)		
Weight Problems					
General: Smoking <input checked="" type="checkbox"/> N Exercise <input checked="" type="checkbox"/> N – how often – <u>2 weekly</u> Alcohol intake <input checked="" type="checkbox"/> N – how much <u>1-2L</u> Water intake <input checked="" type="checkbox"/> N – how much <u>2+</u> Tea/coffee <input checked="" type="checkbox"/> N – how many per day <u>2+</u> <u>Past 12hrs</u> (if applicable) Fever <input checked="" type="checkbox"/> N Diarrhea <input checked="" type="checkbox"/> N Vomiting <input checked="" type="checkbox"/> N Under drug influence <input checked="" type="checkbox"/> N					



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Physical Observations

Please mark any areas of tension, or that you are experiencing pain and discomfort in the diagram below:



Formal Consent

I understand that the services received today, Massage Therapy, Remedial Massage, I receive is provided for the basic purpose of relaxation, stress reduction and muscular tension and most important pure enjoyment. I further understand that the massage, skin treatment, and any other aspects relating to today's treatment should not be construed as substitute for medical examination, diagnosis, or treatment in any manner. The treatments performed today do not take the place of medical treatment where needed. If you are in doubt, please consult your doctor or physician.

Client's Name: Jacqueline Annette

Client's Signature: [Signature]

Date: 20/8/25