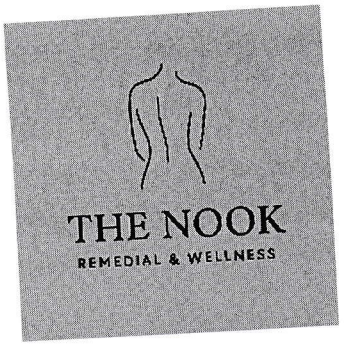
The Nook Remedial & Wellness – New Client Form



Personal information

Title: ~~MS~~

First name: Wendy

Middle name: May

Last name: Kemble

Preferred name:

Mobile number: 0432421086

Ph: Home: ~~Ø~~

Ph: Work:

Email address: wendy.kemble@hotmail.com

Date of birth: 14-11-61

Address line one: 29 seventh st

Address line two:

Suburb: Morgan

State: SA

Country:

Postcode: 5320

Occupation:

Gender: Female

Emergency contact

First name: Julie ~~Carter~~

Last name: Carter

Phone number: 0450603359

Relationship: sister

Referral source

How did you hear about us: Facebook – Sinage

Health History

If you have a history of any of the following conditions, please circle:

- Heart disease
- Musculoskeletal
- Diabetes
- Asthma
- Arthritis
- Severe weight loss/gain
- Headaches ✓
- Autoimmunity
- Dizziness
- Pregnant
- Cholesterol
- Severe fatigue
- Bruise easily
- Blood pressure
- Digestive
- Skin conditions
- HIV
- Epilepsy
- Thyroid
- Jaw or Facial tension/conditions
- Allergies
- Joint replacement
- Pacemaker, internal pins/wires/plates, artificial joints or special equipment
- Other, please advise if there is a Medical Condition we should know about

Health History details

If you answered yes to any of the above, please provide further information here: I get migranes from time to Time

Surgeries

Please list any surgeries you have had:_____

Medicines/supplements

Please list any medications or supplements, including the reasons you are taking them:_____

Alcohol consumption

How much alcohol do you consume on a weekly basis:_____

Smoking

Do you smoke? When did you start and how often do you smoke:_____

Excercise

What type of excercise do you do and how often:_____

Family history

Please list any conditions that run in your family:_____

Repetitive Movement

Please list any movements that you can think of that you complete repetitively most days:_____

Menstrual Cycle (if relevant)

Do you consider your cycle to be normal:_____

Please note anything that is relevant to your Menstrual Cycle:_____

Other

Please add her if there is something else that we may need to know to complete your Treatment:_____

Please answer Yes/No to the following 'Do you, have you or are you' questions:

Been sensitive or allergic to any fragrances or oils? YES/NO

Had a Massage before? YES/NO

Had any recent surgery, wounds, bruises, immunisations? YES/NO

Currently Pregnant? Or been Pregnant in the past 6 months? YES/NO

Current complaint

What is the reason for your visit: Hedaches

When did the problem begin: Young age

Where exactly is the problem located on your body: neck

What caused the problem: _____

What relieves your symptoms: _____

What aggravates your symptoms: _____

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

Have you had Massage before: Yes

Pain scale

On a scale of 1-10 with 1 being minimal and 10 being maximum pain, how would you rate your pain?

1 2 (3) 4 5 6 7 8 9 10

Mood scale

On a scale of 1-10 with 1 feeling very down and 10 feeling great, how would you rate your mood?

1 2 3 4 5 6 (7) 8 9 10

Sleep quality scale

On a scale of 1-10 with 1 being very poor and 10 being excellent, how would you rate your sleep quality?

1 2 3 4 5 6 (7) 8 9 10

Energy scale

On a scale of 1-10 with 1 being very low energy and 10 being very energetic, how would you rate your energy?

1 2 3 4 (5) 6 7 8 9 10

Files

If you have any files/documents such as test results, scans, doctors letters etc, you'd like to share with your service provider, please hand these to your therapist prior to your treatment.

Private health fund details

If you have private health insurance that covers you for natural therapies, please provide your details below. Please note, not all practitioners and/or services are elegible for rebates.

Fund name:_____

Customer/Membership number:_____

Number on card:_____

Informed consent

I have provided a detailed medical history to the best of my ability. I do not expect the therapist to have foreseen any previous or preexisting condition that I have not mentioned. I also understand that massage therapy may produce side effects such as muscle soreness, mild bruising, increased awareness of pain and light-headedness amongst other possible temporary outcomes. I am aware that the therapist does not diagnose illnesses, prescribe medication, nor physically manipulate the spine or its immediate articulations. The therapist understands that I have the right to question procedures used and to receive an explanation of any procedures that the therapist performs. I will tell the therapist about any discomfort I may experience during the therapy session and understand that the therapy will be adjusted accordingly. I understand that all records relating to my treatment will be retained in line with the Australian State and Federal Laws and that I may request a copy of these records at any time. I understand that this information may be shared with my Private Health Fund for the sole purpose of verifying any claim I may make for the service. I understand that a 50% cancellation fee applies if I do not provide at least 24 hours' notice, and all invoices are to be paid in full within 5 business days of issue date.

- I consent to treatment YES/NO
- I consent to receiving SMS and/or emails YES/NO
- I understand that a 50% cancellation fee, applies to any missed appointments, or appointments cancelled with out 24 hours prior notice YES/NO
- I understand that all invoices are to be paid in full, within 5 Business days of issue date YES/NO
- I consent to the use of Coconut Oil or Grapeseed Oil to be used in my Treatment YES/NO
- I consent to the use of Hot/Cool Stones and Towels to be used in my Treatment YES/NO
- I consent to my Upper Buttocks being treated, if this location is relevant to my Treatment YES/NO
- I consent to Essential Oils being diffused in the Treatment space YES/NO

Client Name: Wendy Kemble

Client Signature: [signature]

Date: 31/8/25

- I am the client YES/NO
- I am submitting on behalf of the client YES/NO