BayviewHEALTH

Client History Form

These details will assist with your treatment

Name:_____ Date:_____

Address:_____

Phone:_____ Cell:_____

DOB:_____ Occupation:_____

Marital Status:_____

Email:_____

No. Of Children:_____ Age(s):_____

Sport/Recreational Activities:_____

Per Day	units	Per Week	units
Water		Alcohol	
Caffeine		Work	
Tobacco		Exercise	
Energy Drinks		Sugar/Sweets	
Sleep		Recreational Drugs	

Are you a Vegetarian or Vegan?_____

Current Health:

What is your main issue/area of discomfort?_____

_____

Any other issues/areas to consider?_____

What/how did it happen?_____

_____ When?_____

Please circle

Intensity: Constant Progressive Comes & Goes

Type of Pain: Dull ache Sharp Numb Tender Other_____

Stiff Tingly Sore Stabbing

What improves it?_____

What makes it worse?_____

Does it prevent you: Sleeping Working Exercise

Medical Diagnosis?_____

GP:_____ X-rays:_____ Blood Tests:_____

Any treatment received? (explain)?_____

Was this beneficial? Y/N_____

Have you had a similar condition before?_____ When?_____

How did this happen?_____

_____

Medication: ***Please detail***

Are you currently taking any medication?(Incld homeopathic, herbal, Vit & Minerals)

_____

_____

Are you taking any of the following? ***Please circle***

Laxatives Sedatives Anti-depressants

Insulin Aspirin Anti-inflammatory

Other_____

Have you ever had the following? ***Detail***

Operations: **Y/N**_____

Broken Bones: **Y/N**_____

Been in an accident: **Y/N**_____

Experienced Whiplash: **Y/N**_____

Please circle

Alternative Therapies experience: Often Occasional Never

PLEASE GO TO NEXT PAGE IF NOT RECEIVING MASSAGE THERAPY

Do you have difficulty lying on your back? Back/Front No Side-Lying R/L

What did you enjoy/not enjoy from previous massage therapy?_____

_____

Any areas you wish not to be touched? e.g. feet_____

Please circle any items you are currently wearing:
Contact lenses Hair Piece Hearing Aid Pace Maker Dentures
Do you have any allergies/sensitivities? E.g. oils/lotions/scents

_____

Do you have any open wounds/cuts or sores currently?_____

Do you experience any of the following? ***Please tick***

Headaches		Blood clots		Vision problems	
High/Low Blood Pressure		Varicose veins		Spinal Disc problems	
Numbness/Tingling		Diabetes A/B		Breathing problems	
Sinus problems		Epilepsy		Osteoarthritis	
Ear problems		Asthma		Arthritis/Gout	
Stiff neck		Hernia/Ulcer		Skin problems	
RSI/OOS		Viral condition		Digestive problems	
Pregnancy EDD_____		Heart problems		Diarrhoea	
Fluid Retention		Chest Pains		Constipation	
Allergies		Hepatitis A/B/C		Cancer	
Fatigue		HIV/AIDS		Sleep disturbance	

Therapist Use only:_____

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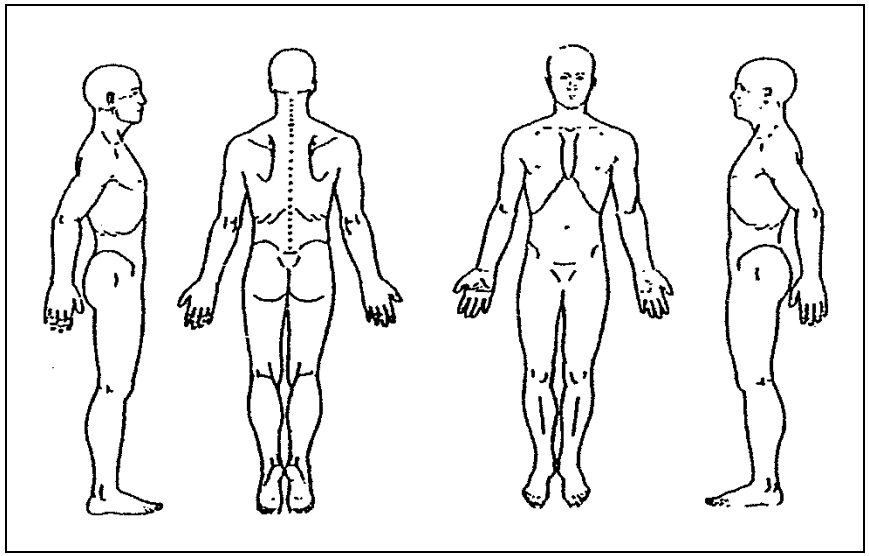
Please indicate areas below areas of discomfort/pain/achiness/tingling etc



To the best of my knowledge the information I have provided is accurate and true. I understand alternative therapy does not take place of any other medical general practitioners (GP). If you experience any unusual effects it is your responsibility to inform your therapist.

Cancellation Policy:
We require at least 12 hours notice to cancel an appointment. Our policy is to charge the 50% of the booking made if you do not show up for your appointment or if you cancel with less than 12 hour's notice.

Signature:_____ Date:_____