CONFIDENTIAL
CLIENT CONSENT FORM

Wellness on the Move – Su Tindall Remedial Therapist
3/5 Selborne St, Mt Gravatt 4122
1019 Winn Rd Mt Samson Qld 4520

Date: _____

Name:_____ DOB:_____/_____/_____

Address: _____

Phone:_____ Mobile: _____ Work:_____

Email: _____Do you wish to receive enews of specials etc? YES / NO

Recreational Activities / Sports (current & past):_____

Occupation: _____ How did you find us? _____

Emergency contact: _____ Relationship: _____ Contact: _____

I understand and accept that all information gathered in this and subsequent consultations will remain strictly confidential and be used only by this practitioners to help determine appropriate treatment and not divulged elsewhere unless requested in writing by myself.
I have reviewed this information and declare it to be accurate to the best of my knowledge.

SIGNATURE: _____ DATE: ____/_____/_____

Doctor: _____ Clinic: _____ Health Fund: _____

Are you seeking 3rd party compensation for your treatment today? Yes / No

For your own best interest, please advise any health conditions including but not restricted to:

Heart, circulation problem	Varicose veins	Hernias
Cancer / tumours	Chronic pain	Epilepsy / Seizures
Warts (hands or feet)	Depression	Blood clot
Abdominal / digestive problems	Rash , athletes foot/tinea	Breastfeeding
Hepatitis B / C / A	Muscle, bone injuries	Pregnant
Blood pressure -High / Low	Osteoporosis / osteopenia	Chronic fatigue
Skin disorders	Asthma or lung condition	Fibromyalgia
Diabetes - Type 1 / Type 2	Hearing problems	Joint Dislocations
Auto Immune Disorder	Phlebitis (vein inflammation)	Headaches / Migraines
Stroke /TIA	Arthritis - Osteo / Rheumatoid	Infectious diseases
Disc injury to spine	Motor accident / trauma	Numbness or Tingling

Additional information: _____

Surgery (all types):_____

Please list medication:_____

Do you have any known allergies? _____

Current symptoms or condition for which you seek treatment today?_____

How long has this condition persisted? _____

Have you found anything that makes it better? _____or worse? _____

Have you received any other treatment for this condition? NO / YES : if Yes, what & when?_____

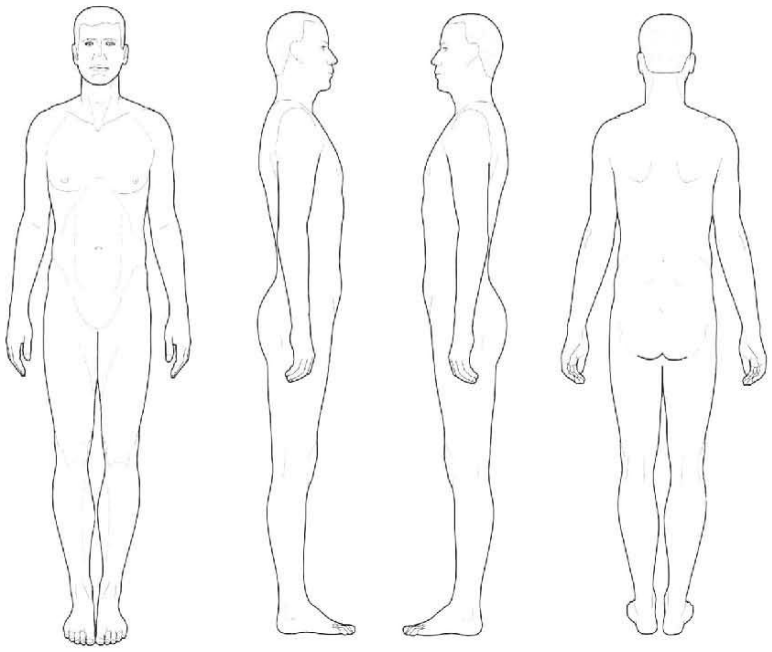
Treatment you have requested today: Massage (Remedial /Therapeutic), Rolfing, Reflexology, Cranio Sacral, other _____

Do you have any specific concerns today about your treatment? _____

Please complete reverse side as well – thank you

Massage or body work

Please indicate the location of your pain



How did this develop?

How long have you suffered from this?

Aggravated by?
(Activities / position / stresses etc)

Type of pain?
(constant / with movement / with activity / sharp / shooting / dull / aching etc)

Relieved by?
(Movement / rest / position / heat / cold)

Previous treatment/tests for this condition:

- ❑ Physiotherapy
- ❑ Chiropractic
- ❑ Osteopathy
- ❑ Acupuncture
- ❑ Deep tissue massage
- ❑ Remedial massage
- ❑ General massage
- ❑ Medication
- ❑ Surgery
- ❑ X-rays / Scans
- ❑ Other _____

Are you looking for a long term solution/management for your discomfort/pain/tightness? Yes/No Or, are you only here for a general massage? Yes/No

Have you ever had a bad reaction to manual treatment (Massage, Physio, Chiropractic etc) in the past? Yes/No

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