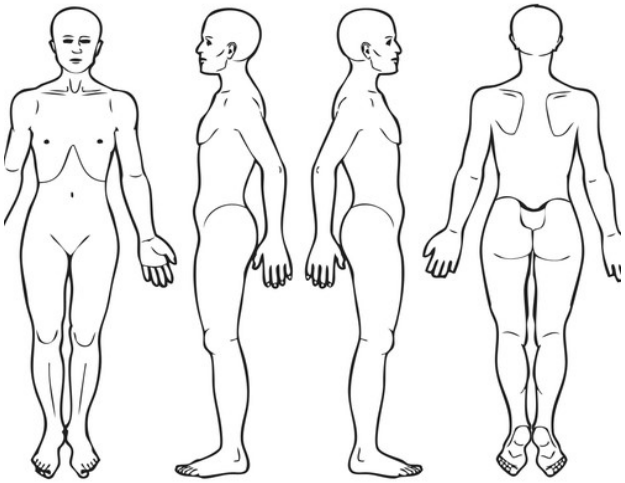
Mernda Myotherapy Clinic - Client History Form

Name :
D.O.B
Address:
Phone No.
Email:
Occupation
Student / Pensioner
Are you currently seeing a doctor /health practitioner/ specialist ? YES / NO **If yes, for what condition(s) ?**
Are you on any medication(s) ? YES / NO
Any other medical conditions or problems we should be aware of past or present ?
What is the main reason for your visit ? e.g Relaxtation / Pain relief / Stress

Please circle where the pain is?



Type of pain / discomfort (circle)			
Sharp	**Stabbing**	**Dull**	**Aching**
Burning	**Numb**	**Tingling**	**Other**

When is the pain worst ?
Morning
Daytime
Evening
Night
Constant

How bad is the pain?		
1 (ok)	**5**	**10 (bad)**

What makes the pain worse / activates pain ?
Does the problem stop you from doing anything ? YES / NO
Have you had massage therapy before? YES/ NO
Are you pregnant? YES/ NO

Private health fund provider:

I (please print name) declare that all the answers and statements contained in this personal record are true and complete. I understand that trapist does not diagnose illness ,disease or mental disorder, or perform any spinal adjustment .Because a therapist must be aware of all past and present physical condition.I have stated all my known medical conditions and take responsibility for keeping the therapist updated on my physical health during any treatment. I consent for this treatment.

Signature : **Date :**