Brisbane Workplace Massage – Confidential Health History Form

Please take the time to provide us with some details, so we can treat you the best way possible

Name	Date
Address ______________________________________ ______________________________________	Phone ______________________________________ Date of Birth
Occupation	Health Fund
Sport / Exercise	Referred by other practitioner or another client?
Email address *(for Health Fund Receipts)* ***I am happy to receive occasional emails and specials: Y / N***	

Please indicate any areas of pain or discomfort

Neck pain	YES / NO	Joint pain	YES / NO
Headaches	YES / NO	Wrist pain	YES / NO
Shoulder pain	YES / NO	Elbow pain	YES / NO
Upper back pain	YES / NO	Hip pain	YES / NO
Lower back pain	YES / NO	Knee pain	YES / NO

Other complaints or issues ____

Injuries

Chronic Injuries YES / NO Details ______________________________________

Acute Injuries (24-72 hours) YES / NO ______________________________________

Are you on any medication/treatment for an Injury? YES / NO

If yes please explain ____

Medical History – *please circle any medical conditions that apply to you, now or in the past*

Do you suffer from the following: Arthritis? Asthma? Cancer? Cold, Flu or Fever? Diabetes? Diagnosed Disc Problems? Dizziness/Fainting? DVT? Eczema? Heart Disease? History of Stroke? High Blood Pressure? Low Blood Pressure? Sleep disorders? Surgery? Vertigo?

Any other conditions please state ____

Female clients - **Are you pregnant?** YES / NO If yes, how many weeks ____________

Description of Pain	Ache / Muscle tightness / Shooting pain / Pins & Needles / Numbness
Massage Pressure	Light / Medium / Firm / Relaxation

I have advised the practitioner of all existing medical conditions and past/present injuries - I agree to keep the practitioner informed if any new medical conditions/injuries occur in the future.

Client signature ____ Date __________________________