BAYSIDE FAMILY CHIROPRACTIC

# Remedial Massage Client Information

| | | | |
|---|---|---|---|
| **Full name:** | | **Date:** | |
| **Address:** **Street** | **City** | **State** | **Post Code** |
| **Best Contact Number:** | | **Secondary Contact Number:** | |
| **Email:** | | **Tick this box if you DO NOT wish to receive our updates/emails:** ☐ | |
| **Date of birth:** | | **Age:** | |
| **No. of children:** | | **Marital status: M S W D** | |
| **Occupation:** | | **Spouse/guardian name:** | |
| **Health Fund Name:** | | **Dr:** | |
| **How did you hear about us?** | | | |

Please tick if you have had, or now have any of the following:

| | | | | | |
|---|---|---|---|---|---|
| ☐ Alcoholism | ☐ Allergy | ☐ Anaemia | ☐ Anxiety | ☐ Arthritis | ☐ Asthma |
| ☐ Blood Clots | ☐ Blood Pressure | ☐ Chronic Pain | ☐ Cancer | ☐ Constipation / Diarrhoea | ☐ Dental / Braces |
| ☐ Depression | ☐ Diabetes | ☐ Diseases / Infectious | ☐ Eczema | ☐ Emphysema | ☐ Epilepsy |
| ☐ Fatigue | ☐ Hernia | ☐ Headaches | ☐ Heart Attack | ☐ Heart Disease | ☐ Hormonal Problems |
| ☐ Injuries | ☐ Low Blood Sugar | ☐ Jaw Problems | ☐ Joint Problems | ☐ Migraines | ☐ Muscle Problems |
| ☐ Nervousness | ☐ Numbness / Tingling | ☐ Pregnant | ☐ Sprains / Strains | ☐ Sinus Problems Tension | ☐ Stress |
| ☐ Stroke | ☐ Tinnitus | ☐ Thyroid Problems | ☐ Ulcers | ☐ Varicose Veins | ☐ Other not listed |

3/5 Town Centre Circuit, Salamander Bay NSW 2317

(02) 4984 6897 www.baysidefamilychiropractic.com.au

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Other not listed / more details

_____
_____
_____

What is your primary reason for an appointment today**?**
What can we help you with?

_____
_____
_____
_____
_____

Have you had experience with massage before?

_____
_____

Are you currently taking any medication, including aspirin, ibuprofen, herbs or supplements?

_____
_____
_____

Please list all forms and frequency of activities, hobbies, exercise or sports participation.

_____
_____
_____

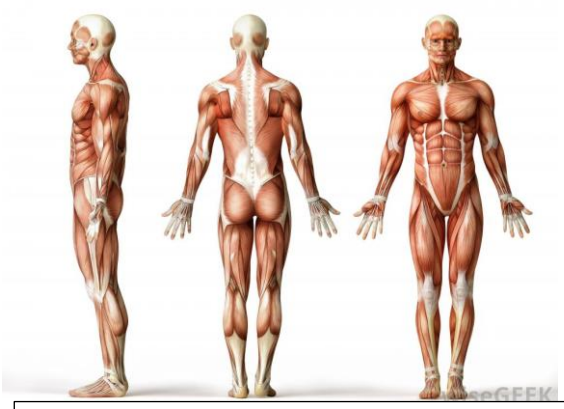
Have you had any accidents or injuries? If so what and when?

_____
_____
_____
_____

Have you had any surgery? If so what and when?

_____
_____
_____
_____

Please indicate your areas of concern.



**CANCELATION POLICY** - If you can't make your appointment 24 hours' notice required so we can reschedule you for another suitable time that week. First time occurrence is a kind reminder of implementation and why. Second time $40.00 missed appointment fee is charged. Cancelation within 3hrs of appointment time or a "No Show" cancelation fee of $79. Therapist are contactors, they don't get paid if you don't show.

I understand that the massage I receive is for the purpose of stress reduction and relief from muscular tension, spasm or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform the massage practitioner so that the pressure or methods can be adjusted to my comfort level. I understand that massage professionals do not diagnose illness or disease or perform and spinal manipulations, nor do they prescribe any medical treatments, and nothing said or done during the session can be construed as such. I acknowledge that massage is not a substitute for medical examination or diagnosis and that I should see a health care provider for those services. Because massage should not be performed under certain circumstances, I agree to keep the massage practitioner updated as to any changes in my health profile, and I release the massage professional from any liability if I fail to do so.

**NAME** _____ **SIGNATURE**_____ **DATE**_____

By my signature I authorise Bayside Family Chiropractic to provide remedial massage to my child or dependent.

**Signature of Parent or Guardian**_____

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