

Massage intake form

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: <input type="checkbox"/>	
Date of birth:		Age:	
Occupation:		Spouse/guardian name and number:	
Health Fund Name:		Dr:	

How did you hear about us?

<input type="checkbox"/> Google	<input type="checkbox"/> Facebook	<input type="checkbox"/> Instagram	<input type="checkbox"/> Local Directories	<input type="checkbox"/> Driving Past	<input type="checkbox"/> Voucher
<input type="checkbox"/> Word of mouth. Who?	<input type="checkbox"/> What's on in our backyard	<input type="checkbox"/> Anytime Fitness	<input type="checkbox"/> Curves	<input type="checkbox"/> iGym	<input type="checkbox"/> Other

Functional Rating Index | For use with **neck and / or back problems** only. To properly assess your condition, we must understand how much your **neck and / or back problems** affected your everyday activities. For each item below, please circle the number which most closely describes your condition **right now**.

Pain Intensity				
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Recreation				
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Sleeping				
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Frequency of all pain				
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Personal Care (washing dressing, etc)				
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Lifting				
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Travel				
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Walking				
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Work				
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Standing				
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

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

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Allergy	<input type="checkbox"/> Anaemia	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Constipation / Diarrhoea	<input type="checkbox"/> Dental / Jaw Problems	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diseases / Infectious	<input type="checkbox"/> Eczema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Hernia	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hormonal Problems	<input type="checkbox"/> Injuries
<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Jaw Problems	<input type="checkbox"/> Joint Problems	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Migraines	<input type="checkbox"/> Muscle Problems
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Numbness / Tingling	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Sprains / Strains	<input type="checkbox"/> Sinus	<input type="checkbox"/> Stress
<input type="checkbox"/> Stroke	<input type="checkbox"/> Tinnitus	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Other not listed

Others 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?



CANCELLATION POLICY

With respect to other clients, we request 24 hours' notice should you need to reschedule or cancel your appointment. We have specifically kept your appointment for you. Cancellation fees will apply should appropriate notice not be given. Cancel or reschedule with less than 4 hours' notice: 50% booked appointment fee - if we cannot fill the appointment. Missed appointment: 100% cancellation fee. Late arrivals will result in an abbreviated appointment.

Please highlight your areas of concern.

Consent | Remedial Massage

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.

Signature _____ Print Name _____ Date ____/____/____

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

Signature of Parent or Guardian _____

Consent | Dry Needling

What is Dry Needling? Dry Needling is a form of therapy in which fine needles are inserted into myofascial trigger points (painful knots in muscles), tendons, ligaments or near nerves in order to stimulate a healing response in painful musculoskeletal conditions. Dry Needling is not acupuncture; in fact, it is modern intervention treatment of pain and dysfunction in musculoskeletal conditions: neck pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, headaches, knee pain, shin splints, plantar fasciitis, or low-back pain.

What are the risks with dry needling? The possible risks and adverse reactions to Dry Needling therapy include but are not limited to temporary pain, bleeding, bruising, infection, dizziness, nerve injury, pneumothorax, pregnancy termination, changes to blood pressure, rash, fainting, muscle soreness & fatigue. Serious Adverse Events (AE's) Pneumothorax, Cardiac Tamponade & damage to organs (0.04%). Mild or moderate AEs included bruising (7.55%), bleeding (4.65%), pain during treatment (3.01%), and pain after treatment (2.19%). Uncommon AEs include aggravation of symptoms (0.88%), drowsiness (0.26%), headache (0.14%), and nausea (0.13%). Rare AEs fatigue (0.04%), altered emotions (0.04%), shaking, itching, claustrophobia, and numbness, all 0.01%. Brady, S et al. Journal of Manual and Manipulative Therapy 2013 VOL. 000 NO. 000 (2013)

Please tick below if you have had any of the following.

<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Spontaneous bleeding or bruising	<input type="checkbox"/> Tendency to bleed – taking anti-coagulant therapy
<input type="checkbox"/> Unstable angina	<input type="checkbox"/> Compromised immune system	<input type="checkbox"/> Previous adverse reaction to acupuncture or dry needling therapy
<input type="checkbox"/> Unstable diabetes	<input type="checkbox"/> Open skin wounds or injuries	<input type="checkbox"/> Recent cardiac surgery or congestive cardiac failure
<input type="checkbox"/> Malignancy	<input type="checkbox"/> Allergy to Nickel or Chromium	<input type="checkbox"/> Congenital or acquired heart valve disease
<input type="checkbox"/> Haematoma	<input type="checkbox"/> Recent radiotherapy	<input type="checkbox"/> Stable or unstable or schizophrenia
<input type="checkbox"/> Peripheral neuropathy	<input type="checkbox"/> Acute cardiac arrhythmia's	<input type="checkbox"/> Pacemaker or any other electrical implants
<input type="checkbox"/> Eczema or psoriasis	<input type="checkbox"/> Cosmetic or surgical implants	<input type="checkbox"/> Seizure induced by previous medical procedure
<input type="checkbox"/> Recurrent infections	<input type="checkbox"/> Chronic oedema or Lymphoedema	<input type="checkbox"/> Other

Statement of Consent – I confirm that I have read and understand the above information, and I consent to having Dry Needling treatments. I understand that I can refuse treatment at any time.

Signature _____ Print Name _____ Date ____/____/____

Consent | Pregnancy Massage

What is Pregnancy Massage? Pregnancy or prenatal massage is used to reduce stress, reduce swelling in the arms and legs and relieve muscle and joint pain in pregnant women. Pregnancy massage can help you cope with the changes to your body that occur while you are pregnant. It can be especially useful to ease discomfort at a time when you can't use some medicines or some other medical options.

Please tick below if you have had any of the following.

<input type="checkbox"/> History of bleeding	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Nausea	<input type="checkbox"/> Hyperemesis gravidarum	<input type="checkbox"/> Fever & malaise	<input type="checkbox"/> Previous miscarriage
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney issues	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Cardiac disease	<input type="checkbox"/> Depression / Anxiety	<input type="checkbox"/> Other

STATEMENT OF CONSENT- I confirm that I have read and understand the above information, and I consent to having pregnancy massage treatments. I understand that I can refuse treatment at any time.

Signature _____ Print Name _____ Date ____/____/____



