MASSAGE THERAPY
NEW PATIENT REGISTRATION FORM

Date:_____/_____/_____

Name:_____ Occupation: _____

Date of Birth:_____/_____/_____ Email: _____

Address: _____

Phone: (H) _____ (Mob.) _____ (W) _____

Emergency Contact Name & Ph:_____

Marital Status: O Married O Defacto O Divorced O Single Number of children_____

GP details: Name _____Ph:_____Clinic:_____

Health insurance: O None O Private _____

Who may we thank for referring you? _____

Main reason for attending?(General wellbeing, Relaxation, Remedial)_____

What is your preferred pressure: O Light O Medium O Firm

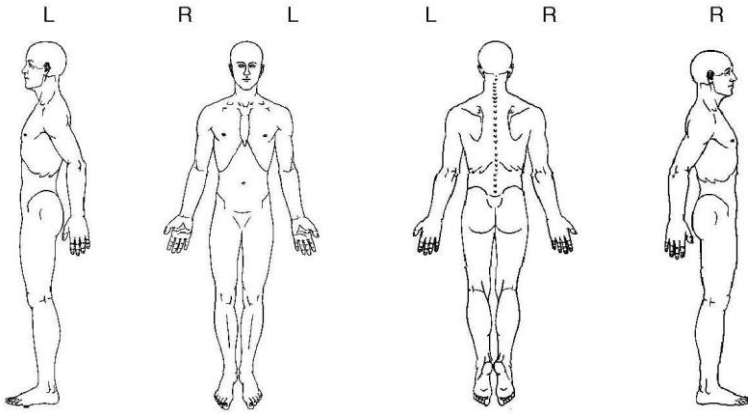
Is the main problem causing:

- O Dull pain
- O Sharp pain
- O Radiating pains

What makes the complaint worse?

_____

_____



Previous treatment:

- O Chiropractor
- O Physiotherapy
- O GP
- O Massage _____

Please mark with an X on the diagram where you are experiencing pain/discomfort/tension/injury

If yes to any of the following please provide relevant details and when they occurred:

- O Previous Injury(fall, sport, car accident)_____
- O Surgeries/Hospitalisations_____

Medications (current/recent)_____

Supplements (current/recent)_____

Are you Pregnant? (please circle) Yes No If yes, how many weeks? _____

Please tick any relevant aliments:

O Alcoholism	O Chest Pain	O Arthritis	O Asthma
O Back pain	O Bloating	O Blurred vision	O Cancer
O Constipation	O Depression	O Diabetes	O Diarrhoea
O Energy Loss	O Eczema	O Epilepsy	O Gas
O Gout	O Headaches	O Heart Disease	O Heartburn/indigestion
O High Blood Pres	O HIV (Aids)	O Irregular periods	O Low Blood Pres
O Menstrual cramps	O Migraines	O Multiple Sclerosis	O Neck Pain
O Ringing in ears	O Sinusitis	O Stroke	O Ulcers
O Vertigo	O Smoker	O Allergy(s) _____	

Is there anything else you would like us to know that has not been discussed?

_____

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OFFICE POLICY

Our goal is to deliver an exceptionally friendly and prompt, professional service providing you with the best in Massage Therapy care. Our experience tells us that there are some key areas we need to focus on to ensure that you receive the greatest benefit from our services.

Mobile Phones: Out of respect for others, please turn off your mobile phone.

Fees and Your Account: Fees for patients are due at the time of service. HICAPS and EFTPOS facilities are available at the front desk for automatic claiming through your private health fund. Workcover and DVA patient accounts will be sent directly to the appropriate body.

Appointment Scheduling: Your Massage Therapist will outline a recommended action plan as the best plan for your injury. You will achieve the maximum results when you keep your recommended action plan to this schedule. Therefore, to receive the most out of your care and to save time we ask that you schedule your appointments in advance.

Missed Appointments: Missed appointments will set you back in your recovery, so we ask that wherever possible you keep all your appointments. If you are unable to keep your appointment, 24hrs notice is appreciated. If less than 24 hours notice is given for a cancellation, a $20 cancellation fee may be charged. Consideration will be given for unavoidable circumstances.

Recovery: Remember that healing and recovery takes time, and not everyone heals/recovers at the same rate. If at any time during your care, you do not feel that you are responding as well as expected, we would ask that you discuss this with your Massage Therapist. We want you to get the most from your care at *The Wellness Place.*

Privacy Policy Statement

In accordance with the Privacy Act, all information relative to your case is held in total confidence. However, your consent is necessary to allow us to exchange information between the practitioners within this clinic. Also when appropriate, relevant information may be sent to other healthcare practitioners for the proper and effective management of your condition.

Disclosure of Medical Condition

Please advise if you are on any medication that may be affected by massage, such as aspirin, Blood pressure/Heart /Cholesterol medications, Cortisone or other that would affect my ability to feel pain.

Indemnity Waiver

I take responsibility for alerting my therapist to any physical conditions that would affect the booked massage appointment.
By signing this waiver, I release The Wellness Place and it's contracted practitioners, from any injury, loss, pain & suffering, or damages suffered by me during the course of, or in any way connected to this massage appointment

I have read, fully understand, and consent to the above the policies.

Patient Name (print) _____

(Guardian name if patient is under 18years)

Patient Signature _____

(Guardian signature if patient is under 18years)

Practitioner's Signature:_____ Date_____