COMPLETE BODY DYNAMICS

1300 256 528
contact@completebodydynamics.com.au
www.completebodydynamics.com.au

Date / /	Name	DOB / /	**State Health Fund (if applic)**
Address			Postcode
Phone	Mobile *(appointment reminders will be sms to this number)*		

Email
Can we include your email address on our mailing list YES / NO *(you can unsubscribe at any time)*

Occupation	Sports/Activities
Have your personal details changed **YES/NO**	*Advise client to see reception to ensure correct details are on database*
Have you had a massage before **YES/NO**	Is this your 1st visit **YES/NO**

Circle Y or N If YES provide details below.

MEDICAL HISTORY	YES/NO	MEDICAL HISTORY	YES/NO	MEDICAL HISTORY	YES/NO
Illness/Injuries/Accidents/Recent Surgery	**YES/NO**	Contagious/Infectious Conditions	**YES/NO**	Respiratory Disorders	**YES/NO**
Fractures	**YES/NO**	Heart/Circulation Disorders	**YES/NO**	Digestive Disorders	**YES/NO**
Spinal Disorders	**YES/NO**	Headaches	**YES/NO**	Blood Pressure **Circle Normal/high/low**	
Pain / Numbness	**YES/NO**	Sleep Disorders	**YES/NO**	Stress Disorders	**YES/NO**
Do you have a referral	**YES/NO**	Circle Written/Verbal	Who is referral from:		

Are you currently taking medication	**YES/NO**	If Yes what and what for:
Are you currently having other treatment	**YES/NO**	If Yes what and what for:
Are you currently pregnant	**YES/NO**	
Do you have any allergies	**YES/NO**	If Yes what
Are you in pain at this present time	**YES/NO**	If Yes, What Sort Why How Long What makes it worse
Do you have any nerve pain/pins & needles at this present time	**YES/NO**	
Have you had any major/recent surgery	**YES/NO**	Clients who have had any significant surgery may be required to wait 10 weeks or provide a Doctors Certificate of consent prior to receiving treatment.
Present condition/s that you would like worked on today		

CLIENT CONSENT TO PERFORM MASSAGE TREATMENTS & POSTURAL ASSESSMENT: Note there may be a $66.00 cancellation fee for unattended appointments made by the client. Please write your name on the line below.

_____understand that the massage I receive is provided for the purpose of relaxation and/or relief of muscular tension or associated problems. If I experience any concerning pain or discomfort during the treatment, I will inform the Practitioner which will enable the Practitioner to adjust the pressure and/or strokes and/or techniques as required. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or a medical treatment. I understand that Massage Practitioners are not qualified to perform deliberate spinal or skeletal adjustments, diagnose, prescribe, or treat any major physical or mental illness, and that nothing said in the course of the treatment given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly to the best of my ability. I agree to keep the practitioner updated as to any changes in my medical history or contact details. I understand that there shall be no liability on the practitioner in relation to a treatment I receive. I also understand and agree that the practitioner has the right to refuse to treat a client whom he/she deems to have a condition for which massage is contraindicated or due to inappropriate behaviour. In signing this assessment form I give consent for the massage treatment and for my contact details to be added to the clinic client information which will enable the clinic to sms appointment reminders and send info regarding special offers.

Client sign <u>ONLY</u> in the presence of the Massage that they agree that the assessment information above is accurate.

Client Signature _____ Date / / Practitioner Initials: _____