NAME:

Email:

Occupation:

DOB:

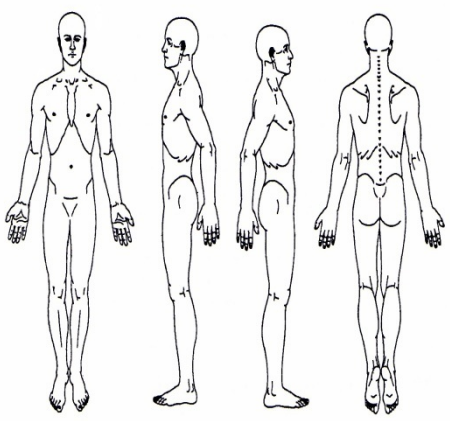
Home Ph: Work Ph: Mobile:

Celeste Woollaston massage therapy

Past Operations/Accidents:	
Type of Exercise/Frequency:	
What is your current problem or symptom?	
What aggravates this problem?	
What relieves this problem?	
Is this getting progressively worse?	Yes/ No Constant Comes and goes
Pain Scale	1 2 3 4 5 6 7 8 9 10

If you have any of the following conditions, please tick where appropriate:

General Health		Head & Neck		Chest & Abdomen	
Allergies/Sensitive Skin		Contact lenses		Abdominal Pain	
Anxiety/Depression		Dizziness/Fainting		Asthma/Hayfever	
Arthritis/Gout		Headaches/Tension		Bladder dysfunction	
Bruise easily		Jaw clenching/Teeth grinding		Chest pain	
Cancer		Migraines		Constipation/Diarrhea	
Diabetes		Painful or stiff neck		Heart Disorders	
Eczema/Psoriasis		Restricted neck movement		Respiratory Disorders	
Fungal Infections		Whiplash. When?		**Medication/Supplements**	
High/Low Blood Pressure		**Back**			
Infection/Influenza/Cold		Upper			
Osteoporosis		Mid		**Stimulants/Water(per day/wk)**	
Poor circulation (hands/feet)		Lower		Coffee/Sugar	Tea/Sugar
Pregnant		Disc problems		**Alcohol**	**Tobacco**
Seizures/Convulsions		Limited Movement		Fizzy drinks	WATER
Sinusitis – current		Pain/stiffness		**Please circle areas of pain/discomfort**	
Swollen glands		X-Rays/Scans			
Shoulders, Arms & Hands		**Hips, Legs & Feet**			
Carpal Tunnel Syndrome		Ankle swelling/weakness			
Dislocations		Cramps			
Limited movement		History of Thrombosis			
Numbness/Pins & Needles		Numbness/Pins & needles			
OOS		Pain/stiffness			
Strains/Sprains		Sciatic type pain			
Tightness &/or pain		Shin splints			
Weakness of grip		Varicose Veins			



Other conditions (not listed above) the therapist should be aware of: _____

NOTES

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please read & sign below:

- I understand that I am required to give correct information regarding my physical health to allow for accurate assessment & treatment to be made by the therapist.
  I am also aware that I am responsible for my own health and that I may be required to participate in exercise/stretches/lifestyle changes suggested by the therapist to aid my rate of recovery.

- I am aware that regular feedback from myself (with regards to pressure, temperature, pain) will ensure that the therapist can work within my comfort threshold.

- I understand that the therapist is not attempting to practice physiotherapy, osteopathy, chiropractic, or any other profession requiring a license under the laws of New Zealand.

- My records are confidential and only disclosed to a third party with my permission.

VERY IMPORTANT
Please give 24 hours notice of cancellation otherwise full payment will be required

Thank you for your consideration

Signature:_____ Date:_____

How did you hear about me?

- ❑ Website
- ❑ Yellow Pages
- ❑ Friend
- ❑ Referral
- ❑ Other. Please specify _____