

NAME:

Email:

Occupation:

DOB:

Home Ph:

Work Ph:

Mobile:



Celeste Woollaston  
holistic healing  
est 2005

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?		<b>Medication/Supplements</b>	
High/Low Blood Pressure		<b>Back</b>			
Infection/Influenza/Cold		Upper			
Osteoporosis		Mid		<b>Stimulants/Water(per day/wk)</b>	
Poor circulation (hands/feet)		Lower		Coffee/Sugar	Tea/Sugar
Pregnant		Disc problems		<b>Alcohol</b>	<b>Tobacco</b>
Seizures/Convulsions		Limited Movement		Fizzy drinks	WATER
Sinusitis – current		Pain/stiffness		<b>Please circle areas of pain/discomfort</b>	
Swollen glands		X-Rays/Scans			
<b>Shoulders, Arms &amp; Hands</b>		<b>Hips, Legs &amp; Feet</b>			
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

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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/stretching/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 \_\_\_\_\_

