East End Movement
Shop 1, 1 Moroney Avenue Newcastle East NSW 2300

Patient Health History

Date_____

Name: _____

Address: _____

Telephone: (m)_____(h)_____

Email address: _____

Date of Birth: _____ Occupation: _____

Do you have Private Health Insurance? _____Health Fund: _____

Referred by: _____

How did you hear about us? (Please Circle)

Internet Search Friend Brochure Sign Website Facebook Referral Flyer

What is your primary complaint? _____

When did you first notice symptoms? Cause? _____

_____

_____

Describe your symptoms_____

_____

_____

What activities or movements *aggravate* your symptoms?

_____

_____

What activities or movements *relieve* your symptoms?

_____

_____

Has there been a previous diagnosis? _____

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Does your condition interfere with? (Please Circle)

Work Sport Daily Life Sleep Social Activities

Have you ever suffered from any of the following conditions? (Please Circle)

Heart Problems	Yes No	Anxiety	Yes No
High/Low Blood Pressure	Yes No	Insomnia	Yes No
Varicose Veins	Yes No	Headaches	Yes No
Blood Clots	Yes No	Migraines	Yes No
Stroke	Yes No	Fatigue	Yes No
Skin Disorders	Yes No	Depression	Yes No
Allergies	Yes No	Seizures	Yes No
Cancer/Tumors	Yes No	Accident/Trauma	Yes No
Asthma	Yes No	Neck Problems	Yes No
Hernia	Yes No	Other Injury	Yes No
Digestive Problems	Yes No	Osteoporosis	Yes No
Arthritis	Yes No	Chronic Pain	Yes No
Numbness/Tingling	Yes No	Fibromyalgia	Yes No

Are you pregnant? (Please Circle) Yes No Weeks/Months?_____ Due Date? _____

Please list *any* previous surgeries, hospitalisations or accidents

_____

_____

_____

_____

Please list any medications taken currently

Med #1_____Reason _____

Med #2 _____ Reason _____

Med #3 _____ Reason _____

Do you have any internal pins, wires or artificial joints? _____

Have you seen any other practitioner regarding this complaint? (Please Circle) Yes No

GP Specialist Physiotherapist Chiropractor Podiatrist Massage Therapist

Informed Consent to Treatment

I _____ (the "Undersigned"), declare the information I have provided is

true and correct to the best of my knowledge. I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my health history form as provided by my therapist and disclosed to the therapist all of those conditions affecting me. It is my responsibility to keep the massage therapist updated on my health history.

I hereby consent for my therapist to treat me for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand this treatment is not a substitute for a medical examination. It is recommended that I attend my General Practitioner for any ailments that I may be experiencing.

I authorise my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

I understand the Cancellation Policy, and that I must provide at least 24 hours notice of cancellation of an appointment. I understand that I may be charged the full fee for a missed appointment if proper cancellation notification is not provided to the clinic.

□ I do not wish to receive email updates, promotions or newsletters in the future

Patient Name _____ Signature of Patient/Guardian_____

Therapist name_____ Date Signed _____