



Southside Health Care

Noarlunga Swimming Complex, Seaman Rd, Noarlunga Centre. Ph 8382 2255.

Massage Therapy New Client Questionnaire.

Welcome to Southside Health Care! Please assist us by filling in the following questionnaire.

Name Mr. Miss Mrs.
Ms. Mast. Dr.
FIRST MIDDLE SURNAME

Address.....
STREET NAME & No. / PO BOX SUBURB / TOWN POSTCODE

Phone Numbers
HOME WORK MOBILE

Email Address..... Date of Birth / /

OccupationName of Spouse or Next of Kin

Who recommended us to you?..... Name of your GP.....

Do you have private health insurance covering massage, if so, which company?.....

Have you seen a massage therapist before?.....

What is the major health issue which prompted your visit today?
.....

When did you first notice your main condition?

What caused it?.....

Have you had any previous treatment for this, and if so what sort?
.....

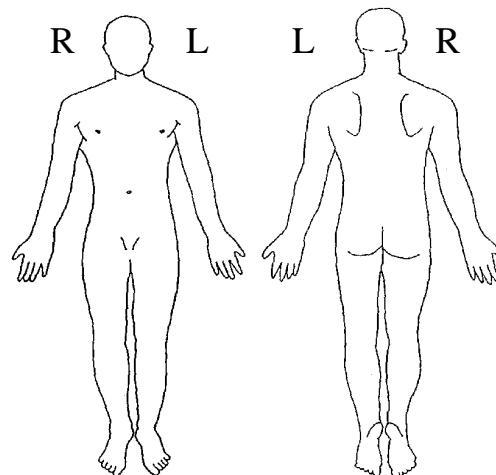
Please list any other health conditions that currently concern you.

1.

2.

3.

Please shade in affected areas:



Are you currently seeing any other health care practitioners? If yes, please give details:.....

Are you currently taking any medication, and if so, what?

Are you currently taking any vitamins or natural remedies, and if so, what?

Do you smoke, and if so, approximately how many per day?.....

What sports/activities are you involved in?.....

Have you experienced any of the following conditions? Please circle:

- | | | | |
|---------------------|----------------------|---------------------------|-------------------|
| Headaches/Migraines | Deep Vein Thrombosis | Cancer | Major Surgery |
| Excessive Fatigue | Neck/Back Conditions | Asthma | Epilepsy |
| Diabetes | Heart Disease | High/Low Blood Pressure | Osteoporosis |
| Anxiety | Depression | Allergies | Sleeping problems |
| Dizziness | Arthritis | Serious Infective Disease | Joint Replacement |
| Bone/Joint Disease | Skin Problems | Pinned or Plated Bones | Current Pregnancy |

Any other major conditions.....

Signature of Patient (or parent/guardian)..... Date / /