Newcastle Chiropractic & Health Centre

CONFIDENTIAL
Patient Information for Massage

Name: ________________________ Date:________________ Occupation:_____________________

Address: ____
Telephone # : CELL________________________ Home: ___________________________________
Date of Birth: *(DD/MM/YY)*:____/____/____ Email Address: _________________________________

Doctor name and Telephone #: ______________________
Have you had a massage before? Y__ N__ How were you referred to this office? _______________
Are you seeing any other Health Professionals:____
Major Complaint bringing you in for a massage therapy:____________________________________

Health HIstory information:

General
_Headaches
Type_______
_Vision Problems
_Hearing Loss
_Epilepsy
_Sinus Problems
_Chronic Pain
_Chronic Fatigue
_Fibromyalgia
_Dizzness
_______Other

Respiratory
_Chronic Cough
_Shortness of Breath
_Smoker
_Asthma
_Chronic Bronchitis
___________Other

Cardiovascular
_High Blood Pressure
_Low Blood Pressure
_Poor Circulation
_Heart Disease
_Phlebitis
________Other

Muscles and Joints
_Stiffness
_Swelling
_Loss of movement
_Back pain
_Shoulder Pain
_Neck Pain
_Pain in Limbs
_Pins and Needles
_Arthritis
Type:___________
_Degenerative Disc
_Whiplash/ When_____
_Family history of Arthritis

Women
_PMS
_Menopause
_Pregnant
Stage:_____
_Gynecological Problems

Skin
_Senstive Skin
_Loss of Sensation
_Rashes
_Bruise easily
_Varicose veins
________Other

Digestive
_Consitpation
_Liver/Gallbladder
_Kidney/Bladder
_diabetes
_Hernia
_Ulcer
_IBS

Other
_Cancer/Tumors
_Depression
_HIV/AIDS

If you checked "Other, please explain:____

Surgery/Injury:
Type:______________________________
Date:______________________________
Current Symptions___________________
Pins/Wires or Plates:________________

Current Medications/ Natural Supplements
____
____
____
____

I understand that the information that I give on this form will be confidential and will be used for the Massage Therapist's clinical records. **I UNDERSTAND THAT I MUST GIVE 24 HOURS NOTICE FOR CANCELLATION OF AN APPOINTMENT OTHERWISE I WILL BE CHARGED THE FULL TREATMENT FEE.**

Date:_________________________________ **Signature:**___________________________________