

CLIENT HISTORY FORM

CLIENT'S PERSONAL INFORMATION

Title	Surname	First Name	Date of Birth	Sex (Male/Female)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Postal Address		Suburb	State	Postcode
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Email	Phone (Home/work)		Mobile	
<input type="text"/>	<input type="text"/>		<input type="text"/>	
Occupation		Company		
<input type="text"/>		<input type="text"/>		
Emergency Contact		Relationship to You	Phone	
<input type="text"/>		<input type="text"/>	<input type="text"/>	

MEDICAL HISTORY

Do you have any allergies/sensitivities? No Yes _____

Are you on any current medications? No Yes _____

Any significant chronic/ongoing medical conditions?
 No Yes _____

Have you had any recent injuries or surgeries?
 No Yes _____

In which part(s) of your body is your injury located? _____

Do you have skin rashes or other skin problems? No Yes _____

Are you pregnant or think you might be? No Yes _____

When was the last time you had a massage? _____

How did you find out about Global Health Centre? _____

CLIENT CONSENT AND SIGNATURE

I hereby declare that I have read the Patient Detail form and that I have provided correct information for Global Health Centre. I acknowledge and understand that I am responsible for payment of all accounts for remedial massage therapy services at the time of treatment. I understand that should I cancel or not attend a scheduled appointment without providing 24 hours' notice that a fee will be charged.

Liability Clause: Global Health Centre accepts no responsibility for treatment received – any professional liability is between the patient and the individual treating therapist. All Global Health Centre massage therapists are insured via their own personal policies.

Patient Signature _____ Date _____