



Massage

Catalyst Health and Wellness Group

602 Barkly Street, Ballarat, VIC 3350

CONFIDENTIAL PATIENT INFORMATION

Welcome to our practice! Please complete all questions and PRINT clearly. Date: \_\_\_\_\_

Form with fields for Surname, First Name, Preferred Name, Address, Town, Post Code, Home Ph, Work Ph, Mobile Ph, Birth Date, Email, Occupation, Employed by, Type of work, Emergency Contact Name and Number, Children's name & ages, Method of payment for first visit, Do you have private health insurance that covers you for remedial massage therapy?, Whom may we thank for referring you to our practice?

Please list your chief complaints in order of severity,

- 1. \_\_\_\_\_ For how long? \_\_\_\_\_
2. \_\_\_\_\_ For how long? \_\_\_\_\_
3. \_\_\_\_\_ For how long? \_\_\_\_\_

Where is the main problem? \_\_\_\_\_

Is the pain [ ] Sharp [ ] Dull [ ] Burning [ ] Throbbing [ ] Like pins & needles?

Does the pain spread? [ ] Yes [ ] No If yes, to where? \_\_\_\_\_

Do you have numbness? [ ] Yes [ ] No If yes, where? \_\_\_\_\_

Is there pain when you cough or sneeze? [ ] Yes [ ] No If yes, where? \_\_\_\_\_

Is there pain when you sit or stand? [ ] Yes [ ] No If yes, where? \_\_\_\_\_

Is the pain getting progressively worse? [ ] Yes [ ] No [ ] Constant [ ] Comes & goes

Do you have headaches? [ ] Yes [ ] No If yes, circle all that apply:

Tension Throbbing Sinus Migraine Other: \_\_\_\_\_

Indicate any function below that aggravates or are aggravated by your condition (please circle all that apply):

Walking Steep climbing Driving Working Recreation Bowel Movements Digestion
Breathing Sinuses Sleeping If female, menstruation Other \_\_\_\_\_

Have you ever experienced Varicose Veins? [ ] Yes [ ] No (Contraindication to having Massage on area)

Does your father, mother, sister, brother or children have similar problems? [ ] Yes [ ] No If yes, who? \_\_\_\_\_

Any Allergies: \_\_\_\_\_

Is there any chance that you are pregnant? [ ] Yes [ ] No If Yes, how many weeks pregnant? \_\_\_\_\_ weeks

Date of onset of last menstrual period (if applicable): \_\_\_\_\_

Have you ever been diagnosed with cancer? [ ] Yes [ ] No If yes, what kind? \_\_\_\_\_

Previous massage care (leave blank if no previous massage)

Previous massage therapist's name: \_\_\_\_\_ Approximate date of last visit: \_\_\_\_\_

Type of care: Symptom based / Non-symptom based (wellness or maintenance)

Techniques used: Relaxation / Deep tissue / Dry needling / Lymphatic / Remedial / Other \_\_\_\_\_

Imaging History			
<input type="checkbox"/> Previous x-rays	Approx. Date: ___/___/___	Area:	Do you have a copy of report?
<input type="checkbox"/> Previous MRIs	Approx. Date: ___/___/___	Area:	Do you have a copy of report?
<input type="checkbox"/> Previous CT scans	Approx. Date: ___/___/___	Area:	Do you have a copy of report?
<input type="checkbox"/> Other imaging	Approx. Date: ___/___/___	Area:	Do you have a copy of report?

Please list any operations you have had:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

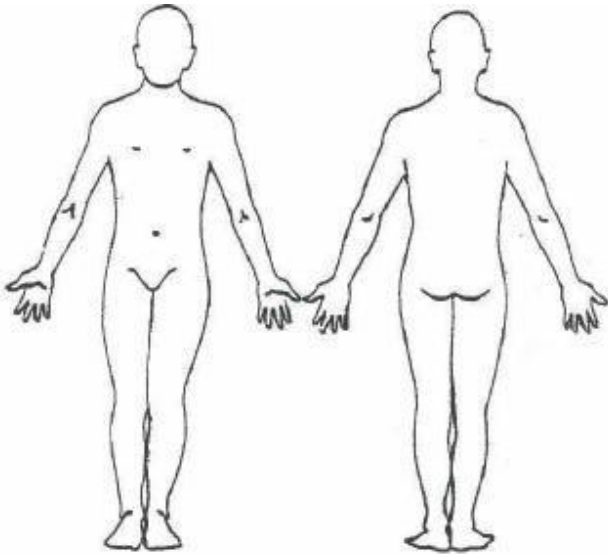
Please list any serious injuries, illnesses or accidents you have had: (including as a child)

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

General Practitioner's Details	
Name:	Clinic name:
Address:	

Please mark areas of complaint on the chart below & indicate the type of pain using the following legend:

Numbness	Pins & needles	Burning	Aching	Stabbing
_____	OOOOOOOO	XXXXXX	*****	//////////
_____	OOOOOOOO	XXXXXX	*****	//////////



**Pain Chart:**

**Neck/Shoulder/Arm Pain**

On a scale of zero to ten, I rate my discomfort as follows:  
 ( \_\_\_\_\_ )  
 0 (no pain) (severe pain) 10

**Mid Back Pain**

On a scale of zero to ten, I rate my discomfort as follows:  
 ( \_\_\_\_\_ )  
 0 (no pain) (severe pain) 10

**Low Back and Leg Pain**

On a scale of zero to ten, I rate my discomfort as follows:  
 ( \_\_\_\_\_ )  
 0 (no pain) (severe pain) 10

When the pain is at its worst, how does it feel? \_\_\_\_\_

What exercise do you currently do and how often do you do it? \_\_\_\_\_

Do you drink alcohol?  Yes  No

If so how much? \_\_\_\_\_

Do you drink caffeinated drinks?  Yes  No

If so how many and what type? \_\_\_\_\_

How many Cups of water do you drink per day?  
 1  2  3  4  5  6  7  More \_\_\_\_\_

## Legs and Feet

1. Do you experience pain in your legs or feet? Yes / No
2. Do you think you have mechanical foot problems? Yes / No
3. Are you interested in general foot care? Yes / No

## Emotional Stress

Please mark the line with an 'x' Is

your work stress

LOW \_\_\_\_\_ HIGH

Is your relationship stress

LOW \_\_\_\_\_ HIGH

Is your family stress

LOW \_\_\_\_\_ HIGH

Is your financial stress

LOW \_\_\_\_\_ HIGH

Do you consider yourself an **emotional, stressful, anxious or depressed** person? Please circle

Have there been moments in your life where you have felt an inability to cope?  Yes  No

Current Medications		
Medication Name	Reason for taking	Dosage

\_\_\_\_\_  
 Patients Signature  
 (parent or guardian to also sign if patient is under 18)

\_\_\_\_\_  
 Patients Name  
 (Printed)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 date

\_\_\_\_\_  
 Remedial Massage Therapists Signature

\_\_\_\_\_  
 Remedial Massage Therapists Name  
 (Printed)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 date

