Massage

**Catalyst Health and Wellness Group**
**604 Barkly Street, Ballarat, VIC 3350**

## CONFIDENTIAL PATIENT INFORMATION

*Welcome to our practice! Please complete all questions and PRINT clearly.* Date: _____

| | | |
|---|---|---|
| Surname: | First Name: | Preferred Name: |
| Address: | Town: | Post Code: |
| Home Ph: | Work Ph: | Mobile Ph: |
| Birth Date: / / | Email: | |
| Occupation: | Employed by: | |
| Type of work: ☐ Sitting ☐ Computer ☐ Standing ☐ Driving ☐ Lifting ☐ Other_____ | | |
| Emergency Contact Name and Number: | | |
| Children's name & ages: | | |
| Method of payment for first visit: ☐ Cash ☐ Cheque ☐ Credit Card | | |
| Do you have private health insurance that covers you for remedial massage therapy? Yes / No<br>If yes, which fund _____ | | |
| 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 you 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** | | | |
|---|---|---|---|
| ☐ Previous x-rays | Approx. Date: ___/___/___ | Area: | Do you have a copy of report? |
| ☐ Previous MRIs | Approx. Date: ___/___/___ | Area: | Do you have a copy of report? |
| ☐ Previous CT scans | Approx. Date: ___/___/___ | Area: | Do you have a copy of report? |
| ☐ Other imaging | Approx. Date: ___/___/___ | Area: | Do you have a copy of report? |

Please list any operations you have had:

1. _____ 2. _____ 3. _____

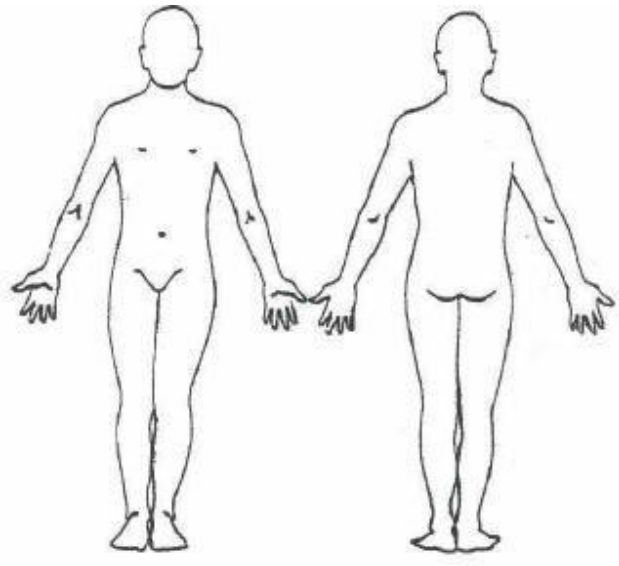
Please list any serious injuries, illnesses or accidents you have had: (including as a child)

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 |
|---|---|---|---|---|
| _____ | OOOOOOOOO | XXXXXX | ******** | /////////////// |
| _____ | OOOOOOOOO | 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