

CLIENT RECORD

Private & Confidential

File Number

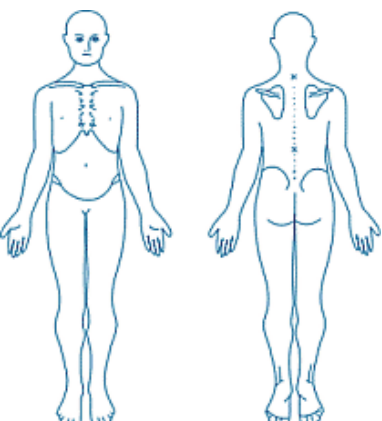
CLIENT DETAILS

Private Health Fund?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fund	Workcover/Claim No		
Name	Surname	Given Name/s			
Address	Number	Street/Road			
	Suburb/Town/City		State	Postcode	
Home	Area Code	Number	Work Phone	Area Code	Number
Mobile	Number		D.O.B	dd/mm/yyyy	
Occupation					
Recreation	Activities/Hobbies/Exercise				
Current Doctor	Name, Address & Phone Number				
Have you had a massage before? Yes <input type="checkbox"/> No <input type="checkbox"/>					

REFERRAL DETAILS

Referred By	Name, Address & Phone Number
Referred For	
Referral Report Requested? Yes <input type="checkbox"/> No <input type="checkbox"/>	

MEDICAL HISTORY

Past Medical History	
Medications—Prescribed or Natural	
Presenting Symptoms	
History of Present Problem	
Description of Pain	<input type="checkbox"/> Dull <input type="checkbox"/> Sharp/Acute <input type="checkbox"/> Radiating <input type="checkbox"/> Throbbing/Pulsating Other
Amount of Pain (1 - 10)	What aggravates pain? What alleviates pain?
Please indicate areas of pain or soreness	Additional Information
	

Please See Over