

# CLIENT RECORD

Private & Confidential

File Number

## CLIENT DETAILS

Private Health Fund? Yes  No  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  No

## REFERRAL DETAILS

Referred By Name, Address & Phone Number

Referred For

Referral Report Requested? Yes  No

## MEDICAL HISTORY

Past Medical History

Medications—Prescribed or Natural

Presenting Symptoms

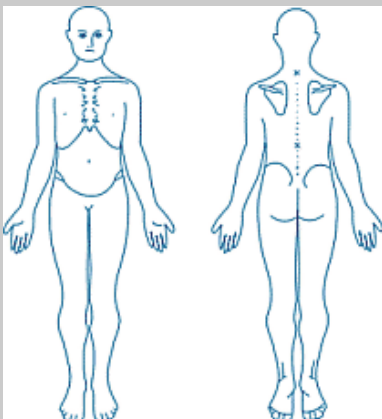
History of Present Problem

Description of Pain  Dull  Sharp/Acute  Radiating  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