yourhealth domain

Massage Therapy Registration Form

Title:_____ First Name: ______________________________ Surname: _________________________

Address: ____

Suburb: ____ Post code: ______________________

Date of Birth: _____/_____/_____

Contact Numbers:

Home: ______________________ Work: ______________________

Mobile: _____________________ Fax: ______________________

Email Address: ____

Occupation: ____

Private Health Fund: ____

Medication/ Allergies (Specifically Nuts): ____

Is this a Workers Compensation Claim? Yes / No

Sports / Exercise	Time per week (e.g. 1 hour)
________________________	________________________
________________________	________________________

Referral Source:
Word of Mouth: Name: _________________________
GP/Specialist: ____
Website: ____
Other: ____

Please tick if you have or had any of the following symptoms/ conditions in the last 12 months:

❑ Chronic Pain	❑ Osteoporosis	❑ Kidney Ailments	❑ Loss of balance	❑ Sleep disorders
❑ Herpes	❑ Cold/Flu/Fever	❑ Psoriasis	❑ Insomnia	❑ Infectious conditions
❑ Blood clots	❑ Numbness	❑ Neck/ Spine injury	❑ Heart Ailments	❑ Joint replacement
❑ Dizziness	❑ Eczema	❑ Epilepsy	❑ Fatigue	❑ Nervousness
❑ A.I.D.S	❑ T.M.J Syndrome	❑ High blood Pressure	❑ P.M.S Syndrome	❑ Allergies
❑ Headaches	❑ Arthritis	❑ Phlebitis	❑ Cancer	❑ Depression
❑ Shingles	❑ Diabetes	❑ Digestion Problems	❑ Varicose Veins	❑ Skin Disorders

What's the main reason for your massage visit today? ____

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Cancellation Policy in accordance with the Australian Physiotherapy Association
Our practice requires 24 hours notice if you wish to cancel your appointment. This provides the practice with the opportunity to offer the appointment to other patients. If 24 hours notice is not provided and you do not attend, you may be charged a cancellation fee. Motor Accident Insurance and Workers Compensation does not cover charges for non attendance. These charges will need to be met by the patient.

Patient Signature: ___________________________ **Date:** _____/_____/_____