WorkFlowMASSAGE

H E A L T H | B A L A N C E | P E R F O R M A N C E

Personal details

Surname: .... Given names: ....

Date of birth: ....

Address

Street: ....

Suburb/city: ....

Postcode: ....

Occupation: ....

Emergency contact person: .... Phone: ....

Contact details

Home: ....

Work: ....

Mobile: ....

Email: ....

Would you like to receive our newsletter via email .... Yes .... No

Health Fund details

Private medical fund: .... Extras: ...... Yes ÁÁÁÁÁÁÁÁNo

Pension/concession card: ...... YesÁÁÁÁÁÁÁÁÁÁÁÁNo

Healthcare card: ..... YesÁÁÁÁÁÁÁÁNo ÁÁÁÁÁÁÁÁÁÁExpire date: ....

Can you claim through Veteran Affairs: YesÁÁÁÁVÁÁÁÁÁNo Card no: ....

Doctor, address, & contract phone number: ....

....

Specialist (if have one): ....

Compensation details **(if applicable or proceed over the page)**

Is this claimable through

Workcover: ...... Yes ÁÁÁÁÁÁÁÁÁÁNo

MVA third party compensation: ..... Yes ÁÁÁÁÁÁÁÁÁÁÁÁNo

Other: ....

Name of insurance company: ....

Name of case worker / manager: ....

Claim number: ....

Employer name: ....

Address: ....

Phone: ....

Medical background

Do you suffer from any of the following?

Diabetes: ..... Yes ĂĂĂĂĂĂNo
High blood pressure: ..... Yes ĂĂĂĂĂĂĂNo
Pregnancy: ..... Yes ĂĂĂĂĂĂĂNo
Heart disease: ..... Yes ĂĂĂĂĂĂĂNo
Osteoporosis: ..... Yes ĂĂĂĂĂĂĂNo
Epilepsy: ..... Yes ĂĂĂĂĂĂĂNo

Ongoing/chronic illness: ....

Allergies: ....

Other medical conditions: ....

Medications: ....

List of surgeries: ....

General History

Have you broken any bones? ....

Have you had any major accidents; car, horse, fall? ....

....

Sports played/exercise taken part in throughout your life: ....

....

Jobs worked: ....

....

Current condition

Do you have x-rays? Yes ĂĂĂĂĂNo ĂĂĂĂĂWhat body part/s? ....

How long have you had your symptoms? ....

Where are your symptoms? ....

How often do you get your symptoms? ....

When are symptoms worst? ....

Can you do anything to relieve the symptoms? ....

Have you had previous treatment? ....

How did you find WorkFlow Massage: (Dr, friend, Family?) ....

**** The supplied client information will be kept in strict confidence, only being released at the client’s approval.***

Patient declaration (to be signed at first appointment)

I .... give consent to the WorkFlow Massage Therapist to treat me in accordance with the Australian Association of Massage Therapists (or equivalent) code of conduct, and under the guidlines of AON Medical indeminty insurance.

Cancellation policy:

24 hours is required for cancellations, failure to do so will incur a 50% fee.

Patient signature: .... Date: ....

If Applicable (18 years or Under):

Parent/guardian signature: .... Date: ....