Trinity Health & Living
Helping you to empower your life

20/200 Goulburn St, Surry Hills NSW 2010

CLIENT MEDICAL RECORD

PERSONAL DETAILS			
First Name:		Private Health Insurance Provider	
Last Name:		Date of Birth:	
Address:		Age:	
Suburb:		Gender:	Male / Female
Mobile/Phone:		Email:	
Emergency Contact:		Phone:	
Family Doctor:		Phone:	
Are you seeing any other health practioners (e.g. chiropractor, physiotherapist, counsellor)? (if Yes, please specify)			
If yes, please specify why:			
Occupation:			
Sports/Hobbies:			

MEDICAL HISTORY
Do you have any existing medical conditions (e.g. any illness, operation, etc)? If yes, what are they?
Are you currently taking any medication? If yes, what is this for?
Have you had any fractures/injuries/accidents? If yes, where and when?
Do you have any other medical issues (e.g. implants, allergies, family history, etc)?

Please turn over

Please indicate whether you have any of the following conditions:

- ☐ Arthritis/Joint Pain
- ☐ Asthma/Chest conditions
- ☐ Cancer
- ☐ Claustrophibia
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting/Black Outs
- ☐ Fluid retention/Swelling
- ☐ Haemophilia/bruising
- ☐ Heart Conditions/problems
- ☐ High/Low Blood Pressure
- ☐ HIV/Aids/Hepatitis
- ☐ Migraines/Headaches
- ☐ Pregnant/Trying to Get
- ☐ Problems with any organs
- ☐ Reproductive problems
- ☐ Sciatica/Back Pain
- ☐ Skin Conditions
- ☐ Stress
- ☐ Stroke
- ☐ Thrombosis/Circulatory condition
- ☐ Tuberclerosis
- ☐ Varicose Veins
- ☐ Vertigo
- ☐ Other (please specify):

GENERAL

What is the main reason for your visit today (e.g. relaxation massage, sports/remedial massage, energy healing)?

How did you find out about us (e.g. internet, word of mouth)?

CONSENT & ACKNOWLEDGEMENT

I have chosen to consult with and give consent for massage therapy to be provided by Diana Nguyen. I have provided a detailed medical history. I do not expect the therapist to have foreseen any previous or pre-existing condition that I have not mentioned. I understand that massage may provide benefits for certain conditions but results are not guaranteed. These benefits may include relief of muscular tension, relaxation, reduction in the symptoms of stress-related conditions and provision of general wellbeing. I also understand that massage therapy may produce side effects such as muscle soreness, mild bruising, increased awareness of areas of pain and light-headedness amongst other possible temporary outcomes. I am aware that the therapist does not diagnose illnesses, prescribe medications nor physically manipulate the spine or its immediate articulations. The therapist understands that I have the right to question procedures used and to receive an explanation of any procedures that the therapist performs. I will tell the therapist about any discomfort I may experience during the therapy session and understand that the therapy will be adjusted accordingly.

Signed (Client/Parent/Guardian): _____ Date: _____

Signed (Practitioner): _____ Date _____

Privacy Statement: Trinity Health & Living is committed to the privacy of its clients. Personal information is treated as confidential and is used only for the purpose for which it was collected. Information kept on file will not be released to a third party without your express consent or as required by law.