Trinity Health & Living

CLIENT MEDICAL RECORD

PERSONAL DETAILS			
Full Name:		Private Health Insurance	
Full Address (including postcode):		Date of Birth:	
Mobile/Phone:		Email:	
Emergency Contact (Name + Phone):		Occupation:	
Sports/Hobbies:		Referred by:	
Are you seeing any other health practitioners (e.g. chiropractor, physiotherapist, counsellor)? (if Yes, please specify and the reason why)			

MEDICAL HISTORY

Please indicate whether you have or had any of the following conditions:

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

Presenting complaint:

CONSENT & ACKNOWLEDGEMENT

I have chosen to consult with and give consent for massage therapy or energy healing 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 or energy healing may provide benefits for certain conditions but results are not guaranteed. I also understand that massage therapy or energy healing 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.

☐ Please tick this box if you do not want to be subscribed to our newsletter and receive promotions from us.