Salus Chiropractic Clinic

# INITIAL CONSULTATION FORM

## Massage Therapy

Date:

### PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| Patient's Given name: Middle: Surname: | | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | D.O.B: Age: |
| Street address: | Suburb: | | | Post Code: |
| State: | Phone (H): ( ) | Phone (W) ( ) | | Mobile Number: |
| Occupation: | Email Address: | | | Do you wish to be sent reminders for you appointments? ❑ Yes (Via SMS/Email) ❑ No |

| | | | | |
|---|---|---|---|---|
| Chose clinic because/Referred to clinic by (please check one box): | | ❑ Dr. | ❑ Health Insurance Provider | ❑ Hospital |
| ❑ Family | ❑ Friend | ❑ Close to home / work | ❑ Yellow Pages | ❑ Other: |

### MEDICAL & FAMILY INFORMATION

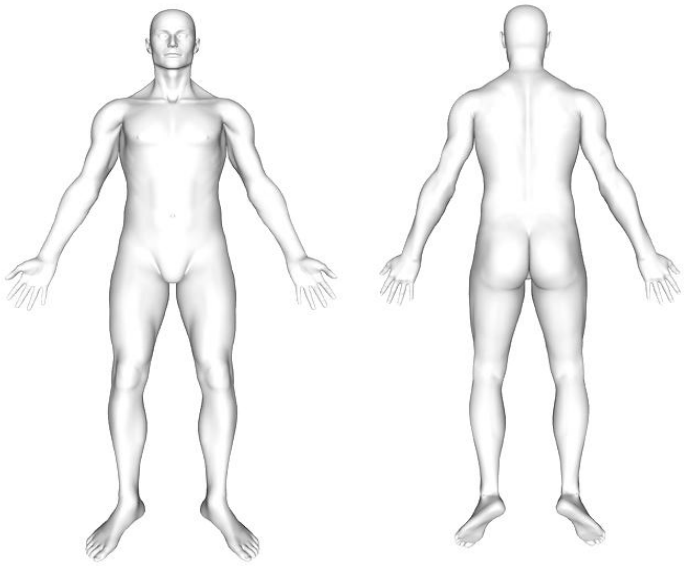
| | |
|---|---|
| Current Medical Practitioner (GP) : | Practice / Clinic: |
| Hospitalisation / Surgeries: | Accidents & Trauma: |
| Current Medications & Supplements: | Family History:<br>❑ Cancer ❑ Stroke<br>❑ High Blood Pressure ❑ Heart Attack<br>❑ Diabetes ❑ Seizures/Convulsions<br>❑ Arthritis ❑ Mental Illness |
| Do you smoke: ❑ No ❑ Yes How much: | Do you drink alcohol: ❑ No ❑ Yes How much: |

Please mark on the diagram where you have pain and/or other symptoms:

Please use symbols to indicate sensation:
**(x)** For pain
**(0)** For numbness/pins & needles

Are your symptoms:
❑ Increasing
❑ Decreasing
❑ Not changing

My symptoms are affecting
❑ General Activities
❑ Leisure
❑ Sleep
❑ Work
❑ Other (please describe):



Health Summary:
(Please indicate if you any of the following)

❑ Excessive bruising / bleeding
❑ Swelling of lymph glands
❑ Unexplained weight loss
❑ Night sweats
❑ Allergies / Skin conditions
❑ Headaches / Migraines
❑ Bowel or Bladder problems
❑ Shortness of breath
❑ Heart troubles
❑ Circulation problems
❑ High or Low blood pressure
❑ Slurred speech
❑ Dizziness / fainting
❑ Cold or Heat intolerance
❑ Pregnant
❑ Sleep disturbances

VAS: On a scale of zero (0) to ten (10) how you rate your current pain?

**(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)**

What are your stress levels like (1 minimal, 10 major/burnout): Work ( ) Home Life ( ) Financial ( ) Health ( ) Other ( )



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# CANCELLATION AND LATE ARRIVAL POLICY

24 hour advance notice is required when cancelling an appointment, except in cases of illness, emergency or inclement weather. Cancellations without 24 hour notice will result in a charge for your session, as that time has been set aside specifically for you.

Please arrive on time for your appointment. Time for your appointment has been arranged for you. If you arrive late your session may be shortened in order to accommodate others whose appointments follow yours. Full payment for your session will be expected.

# CONSENT TO MASSAGE THERAPY

I understand that massage therapy provided by massage therapist is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. I understand that massage may provide benefits for certain conditions but results are not guaranteed. Any other intended purposes for massage therapy are specified below:

……..……
*[Insert Details]*
……..……

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I immediately communicate that to the therapist so the treatment can be adjusted.

I have read the above noted consent, cancellation and late arrival policy, and I have had the opportunity to question the contents and my therapy. I understand that at any time I may withdraw my consent and treatment will be stopped.

| | |
|---|---|
| …… | …… |
| Patient's Signature | (Parent or Guardian to also sign if patient is under 18) |
| …… | …… |
| Patient's Name (printed) | Practitioner's Signature |
| Dated: …… | Dated: …… |



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