

## HOW CAN SOFT TISSUE THERAPY HELP YOU?

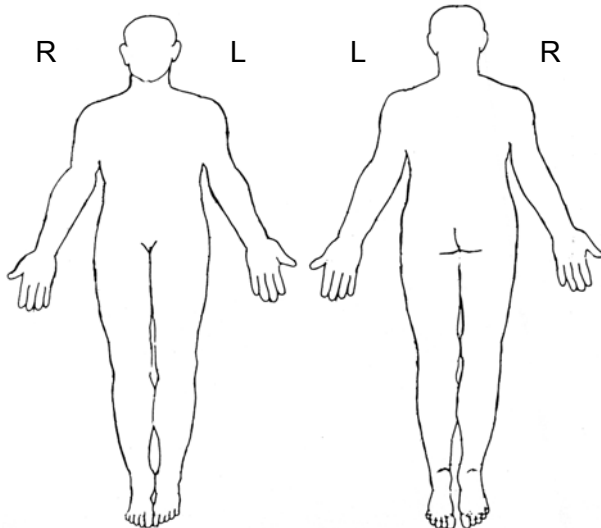
Thank you for choosing Burswood Health Professionals to help you. We aim to provide top class soft tissue therapy (massage), associated with care from other leading professionals. If you need help in completing this form please ask, and remember this information is confidential.

COMPLETE THIS SECTION IF YOU ARE A NEW CLIENT TO THIS CLINIC, Otherwise go to section B.

Full Name	_____	Home Phone	_____
Address	_____	Work Phone	_____
	Postcode _____	Mobile	_____
Occupation	_____	Email Address	_____
Height	_____ <i>cm</i>	Weight	_____ <i>kg</i>
		Date of Birth	_____
Medical Practitioner	_____	Health Cover	_____
Marital Status	_____	Children	_____
Recommended by	_____		

**Relaxation only**  **SECTION B asks about how you feel right now.**

Please indicate where your present symptoms are on the diagram below using the symbols on the right box.



<i>Use these symbols to outline your problem area(s)</i>	
Aching	=====
Pain	=====
Burning Pain	xxxxxx xxxxxx
Numbness or pin & needles	000000 000000
Stabbing	///////// /////////
Other - use your imagination	

Indicate the intensity of your pain on this scale (tick or circle one) **NONE** 1 2 3 4 5 6 7 8 9 10 **WORST EVER**

How long have these problems been present? \_\_\_\_\_ Days / Weeks /Months/ Years

How have these problems interfered with your work or normal activities?

\_\_\_\_\_

Have you had treatment for these problems \_\_\_\_\_ If so, from whom? \_\_\_\_\_

Results of this treatment? \_\_\_\_\_

*Have you ever...* *Circle one* *Explain further:*

- |   |     |    |
|---|-----|----|
| Used blood thinning medication (warfarin) ..... | YES | NO |
| Suffered from a stroke .....                    | YES | NO |
| Used corticosteroid medication.....             | YES | NO |
| Bruised easily.....                             | YES | NO |

**My responses to this form are accurate to the best of my knowledge. Payment for services can be made by cash, cheque, credit card or EFTPOS. I understand that there is a fee for missed appointments. Payment is due when the service is performed. Please check with reception, or your health fund as to which types of soft tissue are covered.**

Client / Parent / Guardian

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

*Your Privacy is important to us. This information will be used in the interests of your continuing health care and will be safeguarded under our Practice Policy on Privacy, to which you can have access on request.*