Client History Form

All information provided is completely confidential

Name:_____ **Date of Birth:** _____

Occupation:_____ **G.P.:** _____

Mob:_____ **Email:** _____

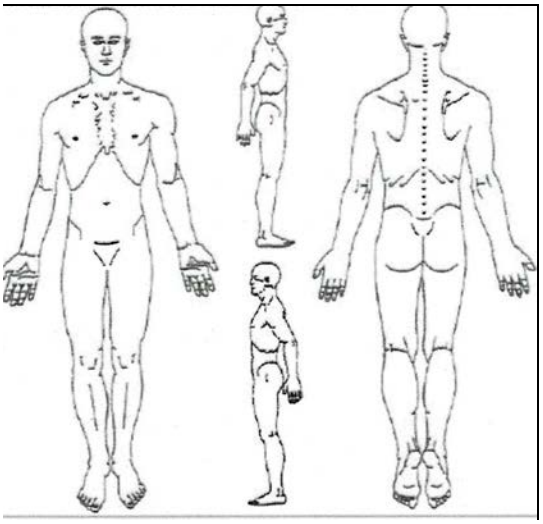
How did you find out about MARINA'S? Advertising/ Signage/ Friend/ Work/ Search Engine/ (circle)

Who referred you : _____

Do you have any of the following conditions? (circle and specify if any apply**)**

Allergies	Operations	Asthma I Breathing Problems
Arthritis/Gout	Skin Conditions	High I Low Blood Pressure
Blood Clots	Easy Bruising	Numbness/Tingling/Sciatica Tendonitis
Cancer	Cold/Flu Frequent	Viral Conditions Digestive Conditions
Heart Problems	Diabetes Type 1 / 2	Vision Problems I Dizziness -Vertigo
Stress I Fatigue I Anxiety	Bone Fractures Pin/ Plates/ Wires	Fluid Retention general or advanced
Accidents I Whiplash I Bursitis	Epilepsy Seizures	Pregnancy (wks) Gynaecological problems
Sleep Disturbance	Migraines/ Headaches	Others

Medication? Specify:



Please mark in the diagram above any areas where you have pain or discomfort.

List any major accidents or surgeries (Including dates)

Sport / Hobbies related to issue? (specify)

Water intake per day
Coffee/Tea
Do you smoke?

Type of Pain? Sharp/ Dull
Does movement help?
Has anyone given you a diagnosis?

Have you had a massage before?
Sensitive to pressure? Pressure preference?
What are your goals from massage treatment?

This massage should feel comfortable. If at any time you experience pain or discomfort, please let your practitioner know.

I understand that massage therapy is designed to be a health aid and does not take the place of a doctors or physiotherapists care and I am aware of the cancellation policy.

Emergency contact name and phone number:

Signed: **Date:**