



PATIENT INTAKE FORM

First Name: _____ Last Name: _____ (Mr. / Mrs. / Ms. / Miss.)

Preferred Name: _____ (Male / Female) D.O.B.*: _____

Phone: (H) _____ (M) _____ Email: _____

Occupation: _____ Address: _____

_____ City: _____ State: _____ Post Code: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Name and contact number of your Doctor: _____

Are you in a health fund? Yes / No Name of Fund: _____

How did you know about us? _____

A day prior to your appointment, are you happy to receive an appointment reminder by SMS? Yes / No

Are you happy to receive monthly emails from us about our updates/specials? Yes / No

***Patient under 18 years of age must be accompanied by a parent or legal guardian**

PATIENT HISTORY QUESTIONNAIRE

Please be sure to fill this out accurately and carefully

- 1) How often do you exercise? _____ times per week
- 2) Describe the exercise activities you do?
- 3) How long have you been working at your current job?
- 4) Any jobs in the past, or type of sport/exercise that you did, you believe may have been a part of the factors that causing the current problem?
- 5) Please list any current medications including vitamins and mineral supplements.
- 6) Please list any allergies.

7) Please outline any past injuries and surgical operations that you have had in the last 10 years.
Which Year? What surgery?

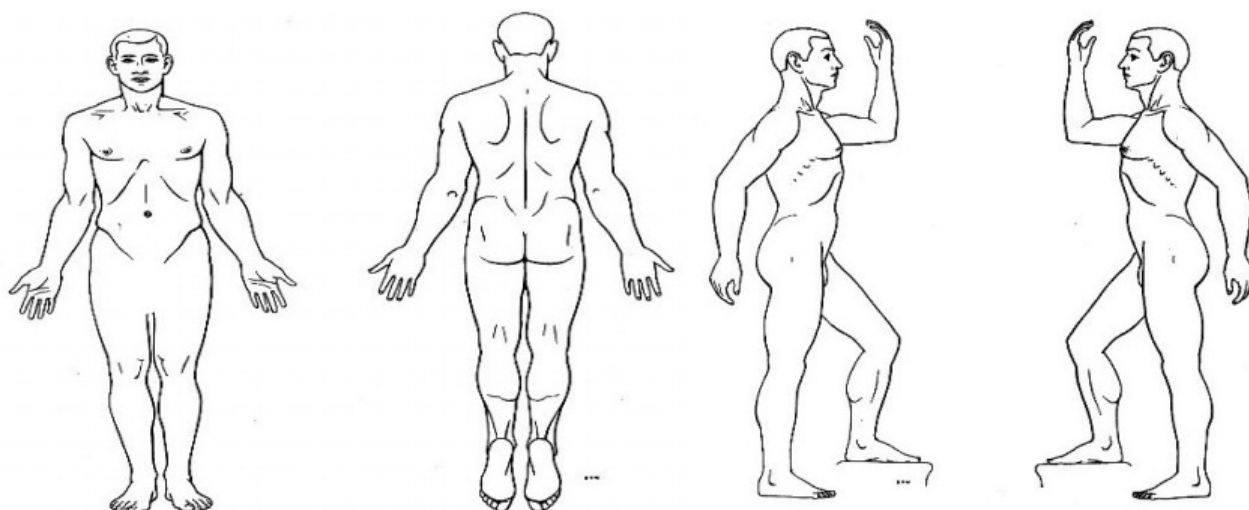
8) Any of the above mentioned injuries were repetitive?

9) If female, are you, or do you think you might be pregnant? No / Suspected / Yes → Week_____

10) Have you ever had any of the following conditions?

	Yes	No	Past		Yes	No	Past
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache / Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis / Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy / Faint / Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whiplash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema / Psoriasis/ Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer – Type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thrombosis / Embolism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis – Type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac / Circulatory problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/ Convulsion/ Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11) Current Complaint - Please circle affected area(s) in diagram below.



CONSENT TO MYOTHERAPY AND REMEDIAL THERAPY CARE

Please read and sign the following:

Personal Questions. Your myotherapist may ask personal questions relating to the reason for seeking treatment and the impact upon your activities of daily living. You shall provide information honestly. The more information you provide, the more likely it is that your therapist can provide effective treatment. In addition, you shall keep your therapist updated as to any changes in your medical profile, and understand that there shall not be liability on the therapist's part should you forget to do so.

Physical Contact. During examination, assessment and treatment, it may be necessary for your myotherapist to make physical contact. Physical contact requires your express consent. You may withdraw consent at any time if you feel uncomfortable.

Risks related to treatment. As with all forms of treatment, there are risks and benefits. Your myotherapist will discuss any foreseeable risks with you prior to administering assessment / treatment. You may withdraw your consent anytime even if you have signed the consent form.

Substituted Consent. Where a person is incapable of understanding the risks and benefits of treatment, consent may be provided by another person legally authorized to provide such consent. Evidence of legal authorization is required in such circumstances.

24 hours cancellation / rescheduling policy. If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you will be charged **50% of the cost for the missed appointment**. On occasion, there will be understandable reasons for missing appointments, but exceptions to this policy will be rare. To make a cancellation or rescheduling, you may contact your therapist directly, by SMS messaging, or by email.

I, _____ (full name) have read and understood the above statements and hereby acknowledge my consent to receive myotherapy / remedial therapy within Equilibrium Muscle Management clinic. I agree to this consent remaining valid until such time as I withdraw my consent.

Patient Signature: X Date: _____

Guardian Signature: _____ Date: _____

(If patient is under age of 18)

Guardian Name in Print: _____