Medical History

NAME:_____

ADDRESS:_____ Postcode:_____

SEX: M F Indeterminate Age: Under 18 18-30 31-40 41-50 51-60 60+

Mobile/Home:_____EMAIL:_____

MEDICAL HISTORY

In the past have you ever had (Indicate No or Yes. Also indicate current if you still have the illness or injury).

MEDICAL CONDITION	NO	YES	CURRENT	MEDICAL CONDITION	NO	YES	CURRENT
Cardiovascular Disease				Elbow, Wrist Injury			
High Blood Pressure/Cholesterol				Knee or Ankle Injury			
Blood Disorders/Diseases				Back or Neck Injury			
Diabetes				Shoulder or Hip Injury			
Contagious Diseases				Skin Conditions			
History of Cancer				Broken Skin			
Asthma				Are you Pregnant?			n/a
Epilepsy			n/a	Varicose Veins			
Stroke				Mental Health			

Give details of injuries to your back, neck, shoulders, elbows, wrists, hips, knees, or ankles in your medical history

_____

List any prescribed medications being taken and what condition/s they are taken for

_____

List any relevant surgical procedures that you have had (write the year in brackets):

_____

ALLERGIES: Do you have any allergies, e.g. Massage Oil NO YES If yes, give details:

_____

Do you have difficulty lying on your back, stomach or side? NO YES If yes, give details:

_____

Please tick the regions of your body that you give permission to the therapist to treat:
Legs Feet Buttocks Stomach Back Upper Chest Arms Neck & Head
*Breast (only for lymphatic purposes and will be discussed and agreed too prior to any treatment)

Cupping Consent - The side effect of cupping is a painless discoloration (bruise) at the cupping site and on rare occasions, a small blister.

Consent for Cupping (Please circle) I do consent I do not consent

Please Note: Underwear Policy

- All clients must wear their underwear during a massage at Jackson Chiropractic P/L and Tension Remedies
- Females have the option to wear or remove their bra depending on comfort. If you choose to not remove your bra, the therapist will unclip it with consent prior to applying oil.

Client Declaration I declare that the above information is to my knowledge true and correct, and that I have not omitted any information that is requested on this form. I declare that I will provide the therapist with any additional health and injury information as it arises prior to any treatment.

SIGNED: _____DATE: _____