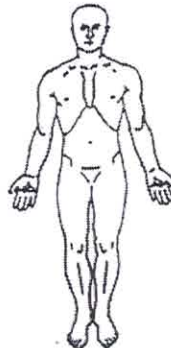
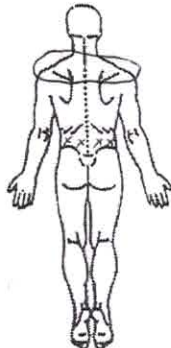


Massage Therapy Case History Form

Patient Name: Laura Strochneller Gender: Male Female Date of Birth: 29.5.1994
 Address: 4/54 Walden Street Newstead Occupation: registered nurse
 Phone: (Home) _____ (Work) _____ (Mobile) 0419 946 343 (Email) laura.strochneller@gmail.com
 Are you in a Health Fund? yes If yes, which one? St Lukes Health Previous Massage? yes
 What is the main reason for your visit? stiffness/tension upper back + neck, lower back
 Please locate on the diagrams below: X for pain; O for stiffness; N for numbness occasional pain



Please rate the pain on a scale of 0 (no pain) to 10 (extreme pain): 2-3

Any allergies? YES NO If so, what? _____

Any contact lenses, prosthetic devices, dentures or pacemaker? YES NO Any chance of you being pregnant? YES NO

Are you currently seeing a medical doctor, chiropractor, osteopath or any other health care practitioner? YES NO

If so, for what condition(s)? chiropractor, endocrinologist - type 1 diabetes

Taking any medication? YES NO What for? reflux, diabetes

Whilst massage therapy is very beneficial, it may sometimes not be appropriate, or it may need to be modified to best suit your needs and state of health. Please circle Yes or No to all the listed conditions listed below and if you currently have or had any of the following in the past, please provide details under Comments below:

Comments		Comments	
Headache	<u>Y</u> <u>N</u> <u>occasional</u>	Indigestion	<u>Y</u> <u>N</u>
Head Injury/Concussion	<u>Y</u> <u>N</u>	Nausea/Vomiting	<u>Y</u> <u>N</u>
Seizures	<u>Y</u> <u>N</u>	Diarrhoea	<u>Y</u> <u>N</u>
Vision Disturbance	<u>Y</u> <u>N</u>	Varicose Veins	<u>Y</u> <u>N</u>
Ear Infection/Pain	<u>Y</u> <u>N</u>	Malnutrition/Weight Loss	<u>Y</u> <u>N</u>
Inflammation	<u>Y</u> <u>N</u>	Infectious Diseases	<u>Y</u> <u>N</u>
Any form of cancer	<u>Y</u> <u>N</u>	Skin Condition	<u>Y</u> <u>N</u>
Chest Pain	<u>Y</u> <u>N</u>	Fracture(s)	<u>Y</u> <u>N</u>
Breathing Problems	<u>Y</u> <u>N</u>	Diabetes	<u>Y</u> <u>N</u> <u>type 1</u>
Asthma	<u>Y</u> <u>N</u> <u>exercise induced</u>	Sprain/bruises	<u>Y</u> <u>N</u>
Tuberculosis	<u>Y</u> <u>N</u>	Fever	<u>Y</u> <u>N</u>
Heart Problems	<u>Y</u> <u>N</u>	Tetanus	<u>Y</u> <u>N</u>
High Blood Pressure	<u>Y</u> <u>N</u>	Any undiagnosed pain	<u>Y</u> <u>N</u>
Back Pain	<u>Y</u> <u>N</u>	Past/Scheduled Surgery	<u>Y</u> <u>N</u> <u>not related to current issues</u>
Should/Hip/Knee Pain	<u>Y</u> <u>N</u>	Other	<u>Y</u> <u>N</u>

I, (PRINT NAME) Laura Strochneller declare that all the answers and statements above are true and complete. I have stated all my known medical conditions and take it upon myself to keep the Massage Therapist updated on my health during any subsequent treatments.

There is a missed appointment fee equal to your consultation fee for any missed or cancelled appointments with less than 24 hours' notice.

Signature: _____

Date: 2.10.21