

## Feel Better Remedial Massage

### Personal information

First name Kelly Last name Patane  
Mobile number 0466 699 754 Email 87kelly@live.com.au  
Date of birth 24 / 01 / 1987  
Address 16 Cremin Street, Upper Mount Gravatt  
Postcode 4122 Occupation Mum/SAHM

### Emergency contact

First name Santo Last name Patane  
Mobile number 0406 636 411 Relationship Husband

### Health History

If you have a history of any of the following conditions, please check below.

- ☐ Heart Conditions   ☐ Diabetes   ☐ Asthma   ☒ Headaches/Migraines   ☐ Dizziness  
☐ Pregnant   ☒ High Blood Pressure treated   ☐ Allergies   ☐ Cancer   ☐ Joint Replacement  
☐ Loss of Balance   ☐ Numbness   ☐ Recent Accident/Injury   ☐ Shingles  
☐ Sleep Disorders   ☐ Blood Clots   ☐ Depression/Anxiety   ☐ Infectious Conditions  
☐ Kidney Conditions   ☐ Neck/Spinal Injury   ☐ Skin Disorders   ☐ Varicose Veins

### Health History Details

If you checked to any of the above questions, please provide further information here.

Surgeries C-section - 10 mths ago, 2.7 years ago

### Current complaint

What is the reason for your visit? Tight neck shoulders, lower back & headaches.  
When did the problem begin? A few weeks ago.

Have you consulted any other health professionals about this problem? If so, please provide details.

### Treatment consent

I have to the best of my knowledge, provided all relevant information about my health and medical history and I give my full consent to treatment. I intend this consent to apply to all future treatments and I understand that I must update my service provider with any changes that may occur in my medical history. I understand that a 50% cancellation fee may apply if I do not provide at least 24 hours notice.

☒ I consent to treatment

☒ I consent to receiving SMS and/or email for booking confirmation

Full Name Kelly Portane

Signature [Signature]

Date 2nd July 2024

**If you are under the age of 18**, your parent/guardian must also sign and date your new client form.

☐ Yes, I'm the parent/guardian. Full Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

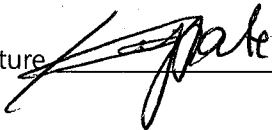
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### CUPPING THERAPY CONSENT FORM

Have you had cupping treatment before? ☒ Yes ☐ No

I (client's full name) Kelly Portane declare that the cupping therapy practitioner has fully explained to me the cupping therapy procedure, benefits, contraindications and possible side effects. I have been made aware that cupping marks may last between 1 to 3 weeks.

Signature



Date

2 / 7 / 24