

## Feel Better Remedial Massage

### Personal information

First name PIETRO Last name BERTOLUCCI  
Mobile number 0420 841 300 Email pietro.bertolucci@hdm.co  
Date of birth 21 / 08 / 90  
Address 39 BLANTYNE ROAD - 4122  
Postcode 4122 Occupation Finance advisor

### Emergency contact

First name CAROLINA Last name HERRERO  
Mobile number 0450 352 100 Relationship SPOUSE

### 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 ☐ 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:

CHRONIC BACK PAIN  
Surgeries LEFT WRIST

### Current complaint

What is the reason for your visit? \_\_\_\_\_

When did the problem begin? JANUARY 25

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

OSTEOPATH

### 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 Pietro Batoletti

Signature [Signature] Date 17/09/23

**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 \_\_\_\_\_