☐ Amanda Cocks, Dipl RM, Dipl Sports Injuries ☐ Freddie Churstain
☐ Sue Hamilton ☐ Nadine Usher-Busch

Maroubra Dynamic Physiotherapy
45 Green Street,
Ph: 9344 7533

Date: ____________________

Client Questionnaire

Client Information

Name: ____

Address: ____

____

Phone: (H)____

(W or M): ____

Emergency Contact Number:______________________________

E-mail Address:_______________________________________

Date of Birth: ____

Occupation:____

Massage Information

Number of massages received before (anywhere)?

Nil ☐ A few ☐ Lots (more than 10) ☐

Depth of pressure preferred: ______________________

Reasons for seeking massage therapy: ______________

____

____

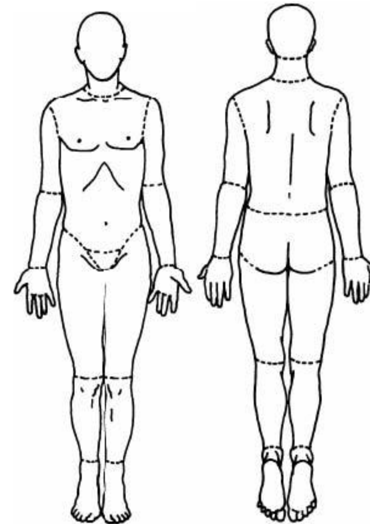
Do you wear contact lenses? Yes ☐ No ☐

Health Fund: ____________________________

How did you hear about this clinic? (Please tick)

Physiotherapy	
Maroubra Massage	
Maroubraphysio.com.au	
Friend/Family	
Google	
Other (Specify) :	

**Please indicate (X)- ** Area(s) that need extra attention (pain,tension,or concern) on the Body Map:



Please indicate (X) any conditions that you have had or currently have:

- ☐ High/ Low Blood Pressure
- ☐ Heart Problems
- ☐ Asthma/Chest Conditions
- ☐ Tuberculosis
- ☐ Thrombosis/circulatory issues
- ☐ Haemophilia/bruising
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Migraines/headaches
- ☐ Fainting/blackouts/vertigo
- ☐ Sciatica/back pain
- ☐ Joint pain/ discomfort
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Cancer
- ☐ Problems with any organs
- ☐ Fluid Retention
- ☐ Skin Conditions
- ☐ Stress
- ☐ Pregnant

Are you currently under medical care? ☐ Yes ☐ No. If yes, what for? ______________________________

List any medications being taken (& what for)______________________________________

Do you have any allergies? ____

Do you have any other disease or condition that you are aware of or have been told of? ☐ Yes ☐ No , If so, what for? ____________

____

Please detail any past history for operations/fractures/accidents/when? ____________________________

____

Would you like to find out more about the Physiotherapy treatment for Chronic Pelvic Pain, Incontinence or Pelvic Floor Weakness?
____

Please Turn Over

Maroubra Pelvic Floor Centre

☐ **Amanda Cocks, Dipl RM, Dipl Sports Injuries** ☐ **Freddie Churstain**
☐ **Sue Hamilton** ☐ **Nadine Usher-Busch**

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Consent,

I, ……………………………………………………………………………………. *understand that the massage therapy given at this clinic is for the purpose of stress reduction, relief of muscular tension or spasm, or for stimulation of the lymphatic system and circulation.*

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the therapist does not prescribe medical treatment or pharmaceuticals, nor performs any spinal manipulations. This therapy is not a substitute for medical treatments and/or diagnosis and that it is recommended that I see a physician for any physical ailments that I may have. I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

I understand that there may be some slight risks involved in this treatment including but not limited to, initial discomfort or reaction, in the form of muscle soreness, possible bruising and joint tenderness in certain circumstances.

I do not expect that the therapist to be able to anticipate and explain all risks or complications, and wish to rely on her judgement during the course of prescribed treatment and to treat me as she feels necessary at the time.

I hereby request and consent to the prescribed course of treatment and use of remedial massage and/or aromatherapy essential oils.

I intend this consent form to cover the entire course of treatment for my present condition and any future conditions for which I may seek treatment.

Signed: : ____Date:______________