KORU MASSAGE
therapies

New Client Health History

Name _____ **Date of first visit** _____

Address _____

Phone _____

Cell _____

Email _____

Date of birth _____

GP and Medical Centre _____

Occupation: _____

Exercise (how often and what type): _____

Past operations (what and when): _____

_____

Injuries (what and when): _____

_____

Previous massages: Y/N

How frequently? _____

Referral source (ie. Sign, internet, word of mouth) _____

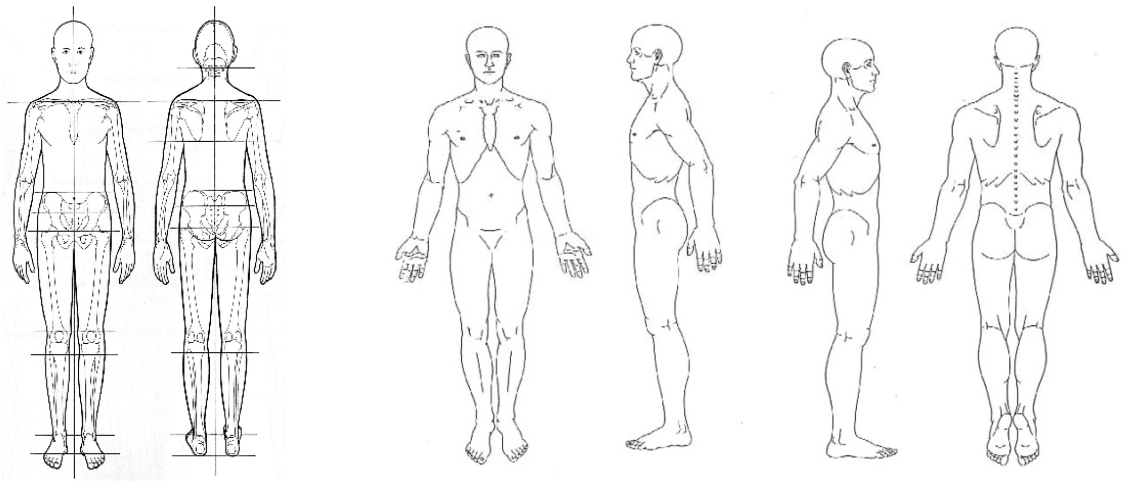
What is your current problem or symptom? _____

_____

Is this getting progressively worse? Yes / No / Constant / Comes and goes

What would you rate your current pain level as? 1 2 3 4 5 6 7 8 9 10

Please circle any area of pain or tenderness



A thorough assessment of the body allows a practitioner to make good therapeutic decisions.

If you have any of the following conditions, please tick where appropriate:

General Health
Allergies
Arthritis
Diabetes
Psoriasis / Eczema
Fungal infections
Influenza / cold
HIV / Hepatitis
Sinusitis
Seizures/Convulsion
High/low bp
Poor circulation
Osteoporosis
Bruise easily
Are you pregnant?

Shoulders & Arms
Pain (front / back)
Dislocations
Weakness
OOS / RSI
Carpal tunnel
Numbness
Pins & needles

Head & Neck
Headaches
Dizziness / Fainting
Jaw Clenching
Teeth Grinding
Head or neck injury
Stiff / painful neck

Spinal Problems
Upper/mid/lower back
Disc problems
Pain/stiffness
Worse when sitting?
Worse when lying?
Previous X-rays?

Hips & Legs / Feet
Sciatica
Knee / hip pain
Knee replacement
Hip replacement
Varicose Veins
Thrombosis / clots
Cramps
Shin splints / Gout

Chest & Abdomen
Heart problems
Angina
Shortness of breath
Asthma
Abdominal pain
Constipation
Diarrhoea
PMT
Heavy Menstruation
Endometriosis

List medication:

List Supplements:

Do you have any other significant health considerations your therapist should know about? (e.g Aneurysm, Cancer, Melanoma, Lymph conditions)
Please list _____
_____
_____
_____
_____

I affirm I have stated all my known medical conditions and answered all questions honestly. I agree to keep the massage practitioner updated as to any changes in my medical profile and understand that there should be no liability on the practitioner's part should I fail to do so.

Cancellation policy: Any appointments missed or cancelled with less than 24 hours notice will be liable to incur the full cost of the appointment missed.

Signature: _____ **Date**: _____