NEW CLIENT INFORMATION

Please take a few moments to complete these forms so we can ensure your treatment is fully customised to suit your needs!

Personal Details		
First & Last Name:		
Street Address:	Suburb:	Post Code:
Email:	Mobile:	
Occupation:	DOB:	
Emergency Contact Name:	Emergency Contact Number:	

Do you wish to receive vouchers and promotions from Health Place?	☐ Yes ☐ No
Do you have Private Health Insurance? Fund name:	☐ Yes ☐ No

How did you hear about Health Place? *(Please Tick)*			
☐ Website	☐ Google	☐ Flyer/Voucher	☐ Stephen Boyd
☐ Urban List	☐ QLD Ballet	☐ Paul Licina & Spine Plus	☐ Passing By
☐ Facebook	☐ Instagram	☐ Other: ______________________________________	
☐ Referred by ____________________________ *(Please let us know who, we'd love to send them a voucher to say thanks!)*			

Treatment Details					
What is your preferred music style for during your treatment? *(Please Circle)*					
Top 40	Chill	Classical	R&B	Spa	Alternative
Chilled Pop	Dance/Techno	Chilled House	Soft Jazz	Country	Any Music
Please circle the corresponding level of FIRMNESS you would like during your treatment:					
Gentle 1	2	3	4	5	Firm
Please circle the corresponding level of CONVERSATION you would like during your treatment:					
Silence 1	2	3	4	5	Chat

CANCELLATION POLICY

All attendances at Health Place are regarded as clinical appointments. We do our best to be on-time with your appointment, and we request that you do the same. Late arrivals will be charged the full appointment amount. If you are unable to attend your appointment, please reschedule it as soon as possible. Failure to advise us of your inability to attend at least 24 hours prior to the appointment will result in a **FULL CANCELLATION FEE**. Exceptional circumstances will of course be given due consideration.

Health Place does not facilitate accounts and payment is expected on the day of your appointment.

I agree to the payment and cancellation policy as described above.

Signature*: ______________________________________ Date: _______________

**Guardian is to sign if the client is under 18 years of age.*

CASE HISTORY: MASSAGE, DRY NEEDLING & A.R.T.

Health Place

YOUR PHYSICAL CONDITION

What is the reason you are seeking our services today? ____
____

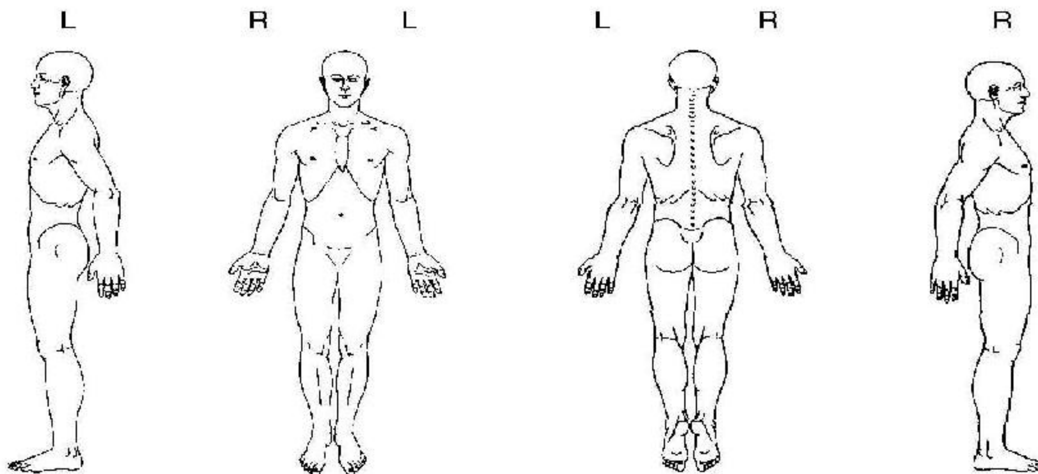
What do you hope to achieve from this treatment? *(Please include any relevant goals or deadlines)*
____

Have you seen any other health professionals for this problem? *(E.g. your GP, Specialists, Surgeons, Chiropractors etc.)* If so, please specify: ____

How long have you had this problem? ____

Have you had this or a similar problem in the past? ____

Please draw on the sketch below the areas where you feel your problem to be:



Pregnancy
Are you, or could you be, pregnant? ☐ Yes ☐ No
If so, how many weeks along are you? _____ What is your expected due date *(Approx.)*? ______________

Do you, or have you ever, suffered from the following conditions/symptoms?

☐ High Blood Pressure	☐ Cancer	☐Spinal Problems	☐Heart Problems
☐ Osteoporosis	☐ Dislocations	☐ Strokes	☐ Rheumatoid Arthritis
☐ Ligament Injuries	☐ Diabetes	☐ Ankylosing Spondylitis	☐ Cartilage Injuries
☐ An Aneurysm	☐ Dizziness	☐ Osteoarthritis	☐ Other

Client Signature* ______________________________ Date: _____________________________________
Practitioner Signature __________________________ Date: _____________________________________
**Guardian to sign if client under 18years of age.*