

# Health History and Entrance Form

- please let us know if your status changes.



POSTURE LINK  
massage | stretch | exercise

\*\*\*BELOW FOR THERAPIST USE ONLY\*\*\*

First Name \_\_\_\_\_

Surname \_\_\_\_\_

Male      Female

Birthday    /    /

Email \_\_\_\_\_

Suburb & Postcode \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Emergency contact name. and number?

Hobbies, Activities, or sports?

Your Occupation?

Private Health Insurance? Member Number?

Work Safe Claim Number?

How did you find out about us?

Have you had a massage before? How often? Type?

Have you seen any other healthcare practitioners?

- Chiro      Physio      Osteo      Naturopath
- Myotherapist      Acupuncturist      Other?

## Please give details about any of the following...

Allergies/Hypersensitivities?

Major accidents?

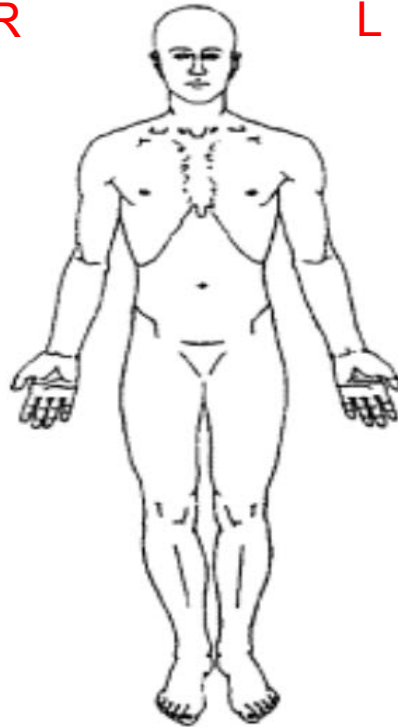
Current medications?

Current serious medical conditions?

Previous major illness or operations?

**\*What's the main reason for your visit, please give detail?**

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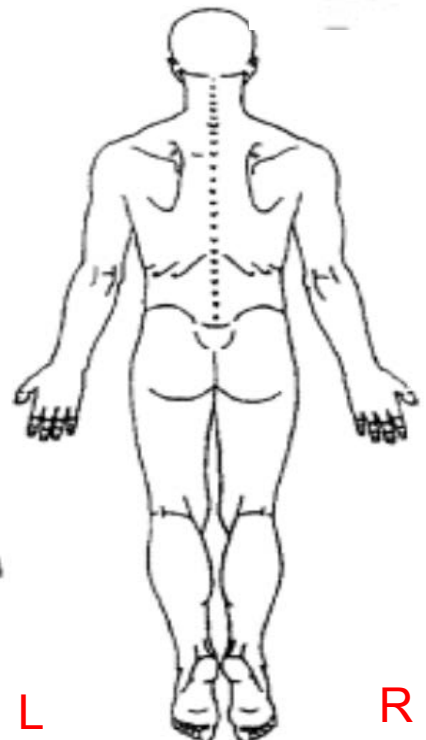


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**Please tick if any of the following apply to you:**



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**General Symptoms**

Dizziness  
Vertigo  
Difficulty Sleeping  
Fatigue  
Stress  
Headaches Migraines  
Nervousness  
Numbness, where?  
  
Tingling, where?

**Immune, Nervous system, Joints**

Arthritis  
Osteoarthritis (OA)  
Infectious Arthritis  
Psoriatic Arthritis (PsA)  
Ankylosing Spondylitis (AS)  
Bursitis  
Metabolic Arthritis (gout)  
Rheumatoid Arthritis (RA)  
Lupus (SLE)  
Immunodeficiency  
Systematic Sclerosis  
Multiple Sclerosis  
Neuromuscular Conditions  
Epilepsy  
Fibromyalgia  
Osteoporosis  
Artificial implants/pins/plates,  
What type and where?

**Cardiovascular**

High Blood Pressure  
Low Blood Pressure  
Heart attack/disease  
Congestive heart failure  
Stroke  
Aneurysm  
Heart Murmur  
Pacemaker  
High Cholesterol  
Cold Hands/Feet  
Varicose Veins  
Phlebitis  
Deep vein Thrombosis  
Thrombocytopenia

**Gastrointestinal**

Poor appetite  
Excessive appetite  
Excessive thirst  
Gas  
Bloating  
Colitis  
Crohn's  
Constipation  
Diarrhea  
Nausea  
Vomiting  
Stomach Ulcer  
Abdominal Cramps  
Gall Bladder Problems  
Liver Problems

**Skin**

Rashes  
Excessive dryness  
Acne  
Psoriasis  
Eczema  
Bruise Easily

**Infections**

Tuberculosis  
HIV/AIDS  
Herpes  
Athlete's foot  
Warts  
**Respiratory**  
Chronic Cough  
Bronchitis  
Shortness of Breath  
Emphysema  
Asthma

Diabetes, what type?  
  
Depression  
Anxiety  
Thyroid problems  
Mental Illness  
Cancer, where?

**Male / Female**

Prostate  
Menstrual irregularity  
Menstrual cramping  
Breast pain  
Breast lumps  
Menopausal  
Pregnant or Planning?  
Give details...

**EENT**

Vision problems  
Dental Problems  
Sore Throat  
Earaches  
Hearing Difficulty  
Hearing Aid  
Stuffed nose.  
Sinus issues  
Swollen Glands, type, where?

**Any additional information you would like us to know, please state below.**

I recognize that Posture Link is not able to provide me with medical advice regarding my current health situation and that all information given to me is to be used for educational purposes as a guideline only.

I agree that Posture Link is not liable for any loss, damage, or injury to me suffered because of safe and reasonable manual therapeutic treatments and exercise training which involve stretching, massage, massage oils, essential oils, cupping, dry needling, kinesiology taping and training. All therapists & trainers have approved certificates and diplomas and registrations.

Posture Link strongly suggests individuals undertaking any exercise or treatment program should consult their doctor before commencing sessions or treatments.

**I declare that all information above is truthful.**

DATE

/ /

FULL NAME

SIGNATURE

PARENT OR GUARDIAN NAME