

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?

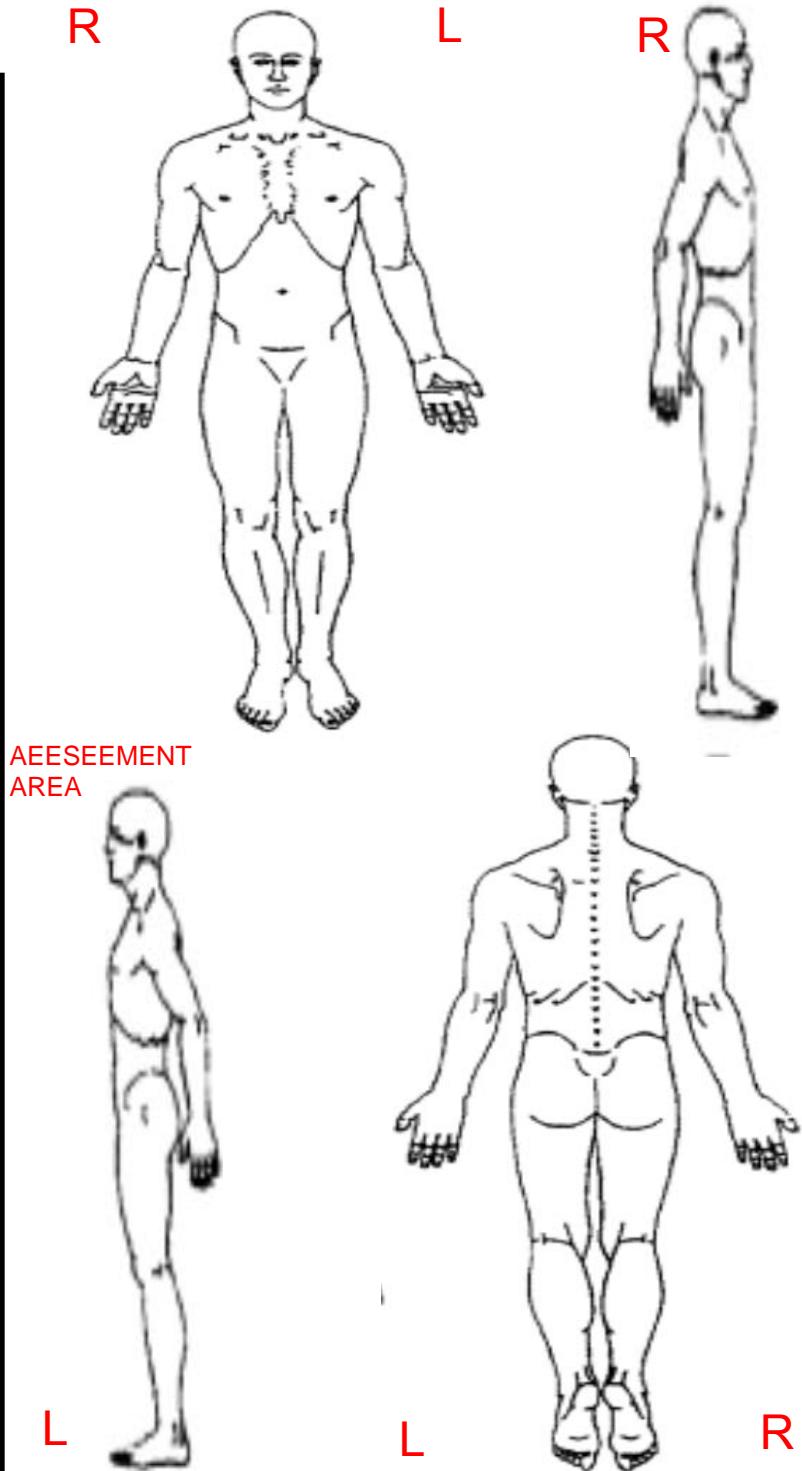
Major accidents?

Current medications?

Current serious medical conditions?

Previous major illness or operations?

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



C :LST-prevention / 3TP / muscles / 30%P / Check / Q / S - M - L & N _____
 Posture : Internal (organs) / External (muscle joints) / Sleep _____
 O :A: _____ B: J.(S-E&R) _____ C: note _____ D: Exercise + = body care + _____

ABOVE FOR THERAPIST USE ONLY

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

Systematic Sclerosis
Multiple Sclerosis
Neuromuscular Conditions
Epilepsy
Fibromyalgia
Osteoporosis
Artificial implants/pins/plates,
What type and 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?

Infections

Tuberculosis
HIV/AIDS
Herpes
Athlete's foot
Warts

Respiratory
Chronic Cough
Bronchitis
Shortness of Breath
Emphysema
Asthma

Depression
Anxiety
Thyroid problems
Mental Illness
Cancer, 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