

**MOOLOOLABA OSTEOPATHY AND MASSAGE CLINIC**

**CLIENT RECORD SHEET – MASSAGE CLINIC**

Surname..... First name..... Date of birth.....  
Address..... Suburb.....State .....

Telephone: Home..... Work..... Mobile.....  
Email .....

Occupation..... Exercise activity.....

**Reason for treatment today**.....

**Do you have any of the following conditions?**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Allergies             | <input type="checkbox"/> High blood pressure    |
| <input type="checkbox"/> Neck or spine injury | <input type="checkbox"/> Skin disorders        | <input type="checkbox"/> Varicose veins         |
| <input type="checkbox"/> Numbness             | <input type="checkbox"/> Infectious conditions | <input type="checkbox"/> Blood clots/thrombosis |
| <input type="checkbox"/> Referred pain        | <input type="checkbox"/> Cold/flu/fever        | <input type="checkbox"/> Pregnancy              |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Inflammation          | <input type="checkbox"/> Rheumatoid Arthritis   |

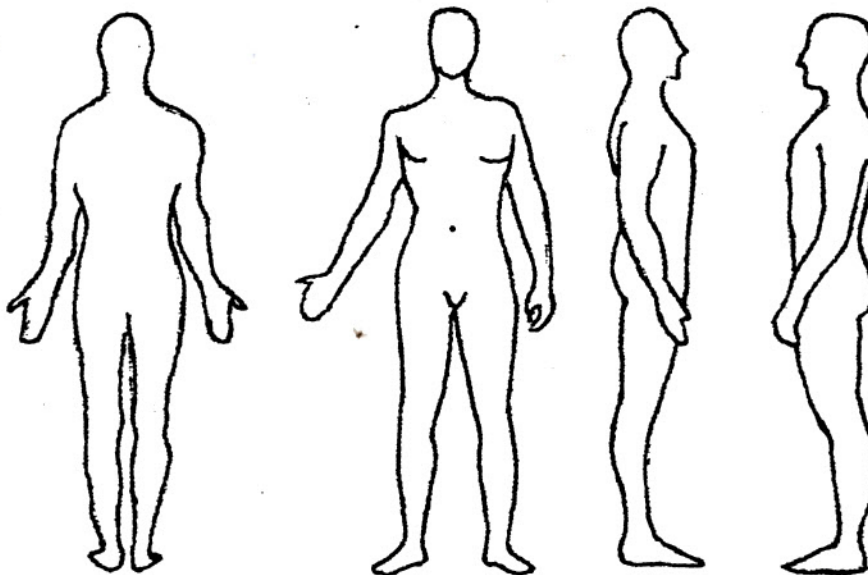
**Injuries or recent surgery**  Yes  No .....

**Medication currently taken for** .....

**Are you currently under the care of another health care professional?**

- GP     Physiotherapist     Chiropractor     Osteopath     Specialist

**What made you decide to come to this Clinic?**.....



**Please mark areas of pain or discomfort on the above diagram**

Client's signature.....Date .....