Vincent Leo ©
Ph: 0407 229 302
www.acnh.com.au

CONFIDENTIAL CLIENT INFORMATION

Name: _____

Address: _____ _____

City: _____State: _____Post Code: _____Date:_____

email:_____

Telephone (H): _____ Work: _____Mobile: _____

Birth Date: _____ Height: _____ Weight: _____

Physician: _____ Ph: _____Medication: _____

Referred by: _____Occupation: _____Employer: _____

Primary reason for appointment:

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING THE APPROPRIATE ANSWER

Have you had a professional massage? Yes / No Are you pregnant? Yes/No

Have you ever had surgery? Yes / No Have you ever had Cancer Yes / No

If you answered YES – In the last 3 months _____

Back, neck, leg or shoulder problems. Yes / No Do you find it hard to relax or chill out? Yes / No

Is your back, neck and, shoulder constantly or occasionally tight and you have the need to stretch to release the strain and tension? Yes / No Are you in a Stressful occupation Yes / No

Do you suffer with headaches? Yes / No Do you suffer with heart problem? Yes / No

Do you suffer with blood pressure? Yes / No Do you have varicose veins? Yes / No

Ever suffered with blood clots Yes / No Do you suffer with constipation Yes / No

Do you suffer with joint pains? Yes / No Do you suffer with muscular pains Yes / No

Are you constantly tired? Yes / No Have you suffered an acute injury Yes / No

DO YOU LIKE A FIRM, LIGHT OR HEAVY MASSAGE? Please circle the appropriate one.

Please explain YES answers: _____

_____

Do you have any medical condition I should be aware of? Please specify:

_____

Do you have private health insurance coverage and with whom?

_____

I, _____, understand that the massage therapy given here is for the purpose of stress reduction, relief for muscular tension or spasm, or for increasing circulation.
I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist prescribes neither medical treatment, nor pharmaceuticals, nor performs any spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and /or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.
Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions, and take it upon myself to keep the massage therapist updated on my physical health.

Signature: _____ Date:_____