Sydney Stretch Therapy
Suite 13, Level 3, 88 Pitt Street
Sydney NSW 2000
Cherie Seeto 0410 595 789
Dave Wardman 0431 021 197

Date: _____ Referred by: _____
Name: _____ Occupation: _____
Address: _____
Email: _____
Mobile: _____Work: _____ Home: _____
Birthday: _____
Marital Status/ Partner's name: _____
Children's names and ages: _____

Stretch Therapy & Massage History

Do you have regular remedial massage? _____ Last massage: _____
What are your expectations for this session? _____
Weekly exercise type and duration: _____
_____
Other stress reduction or leisure activities: _____
_____
Are you pregnant? _____ How many weeks? _____
Please tick all that apply:

_____ Allergies	_____ TMJ/Clenching	_____ Cancer: Type_____
_____ Arthritis	_____ Neck Pain	_____ Carpel Tunnel
_____ Osteoporosis	_____ Sinusitis	_____ Cold Hands/Feet
_____ Bruise easily	_____ Diabetes	_____ Sciatica left or right?
_____ Hi/Lo Blood Pressure	_____ Fibromyalgia	_____ Back Pain (Where?)
_____ Headaches/Migraines	_____ Stiff joints	_____ Tendonitis (Where?)

List any significant injuries, illnesses or surgeries? _____
_____
_____
Are you still under a physicians care? _____
List all current medications, pain killers and supplements: _____
_____
Do you have frequent or chronic pain? _____
When did this start & how? _____
Where? _____ Worse when..._____
Diet: Non-specific Vegan Vegetarian Low Fat Low Carbohydrate High Protein
Weight: _____in kilograms Average Under Over
Height: _____ Cigarettes per day:_____
Daily Fluids: Coffee_____ Tea_____ Juice_____ Water_____ Alcohol_____
Sleeping posture: On back On front On side Number of pillows_____ Hours_____

The above information is accurate and true to the best of my knowledge. If there are any changes in my current level of health, I will inform the proper health care providers of my condition. I understand that the massage therapist does not diagnose illness or disease and does not prescribe medications. If for any reason cancellation is necessary. I will give 24-hour notice. I understand that if I do not give this notice, I will be charged for the missed appointment in full or less than 24-hours notice for half the price of the booked session unless it can be filled.

Signature_____Date_____