

Optimal Health Centre Braddon, 8/14 Lonsdale Street, Braddon, ACT, 2612. (02) 6162-2919

Surname: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Name: \_\_\_\_\_ L handed – R handed

Address: \_\_\_\_\_  
\_\_\_\_\_

Suburb: \_\_\_\_\_ Postcode: \_\_\_\_\_

Postal address: \_\_\_\_\_  
(If different) \_\_\_\_\_  
\_\_\_\_\_

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

Work Phone: \_\_\_\_\_

Preferred email: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_  
(If referred by friend, please give name)

Would you like to receive our email newsletters: Please circle: **(YES) (NO)**



---

**Monday Reminder SMS**

---

Would you like to receive an SMS about available appointments? These are sent Monday mornings. Please circle: **(YES) (NO)**

---

**Presenting condition**

---

**Why have you come for a massage today?** (E.g. Knee pain, stress relief, headaches, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

---

**Medical information**

---

**Are you taking any medication? (YES) (NO)**

Details below: (E.g. high blood pressure, aspirin, pain killers, blood thinners, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you suffer from any of the conditions listed below? (YES) (NO)**

(Tick appropriate)

- |  |  |
|--|--|
| <input type="radio"/> Blood pressure<br>(Circle appropriate: High / Low) | <input type="radio"/> Joint reconstruction<br>(Details below please) |
| <input type="radio"/> Diabetes (No medication needed)                    | <input type="radio"/> Arthritis<br>(Details below please)            |
| <input type="radio"/> Skin conditions (Details below please)             | <input type="radio"/> Migraines (How often, severity?)               |
| <input type="radio"/> Fused joints (Details below please)                |  |

Others/Details (if unsure, ask your therapist):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you had any surgery in the last 3 months? (YES) (NO)**

(E.g. Knee reconstruction, joint fusion, skin moles removed, cosmetic surgery, etc.)

If yes please give details:

---

---

---

**Have you had any other surgery? (Older than 3 months)**

---

---

---

**Do you have any allergies? (YES) (NO)**

If yes please give details (E.g. Nuts, citrus, etc...)

---

---

---

**Do you have any other relevant issues?** (E.g. Chronic pain, repetitive stress injury, stress, pregnancy, car accident(s), etc... If unsure, ask your therapist)

---

---

---

---

---

**Privacy**

We will not give or sell your personal information to anyone without your written consent. We may give your information if we are required by law to do so.

---

**Cancellation policy**

Dear valued client, this cancellation policy applies to patients with appointments for MASSAGE THERAPISTY ONLY. Here at Optimal Health Centre Braddon we believe in fairness so therefore this cancellation policy will also apply to the massage therapists themselves.

The full fee is to be paid if you call to cancel your appointment with less than 3 hours of notice. The therapist will give you a free massage if they cancel on the day of your appointment without being sick.

There will be no cancellation fee if you are sick but please give plenty of notice. If you have any contagious disease (i.e. cold, flu, gastro, etc.) please do not come for your massage. If unsure, call your therapist. If the therapist is sick, someone will call you as soon as possible to cancel.

---

**Declaration**

I declare that the information I provided is true and correct at the time of signature and will tell the therapist if any condition(s) change. I have also read and understood the privacy & cancellation policy. Please ask your therapist if you need more information.

***For clients 15 or younger a parent or guardian must be present during the massage.***

Name of guardian if client is 15 or younger: \_\_\_\_\_

Relationship with guardian: Mother / Father / other: \_\_\_\_\_

Signature of guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_