



Cherie Seeto
 Sydney Stretch Therapy
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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:

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> TMJ/Clenching | <input type="checkbox"/> Cancer: Type _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Carpel Tunnel |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Cold Hands/Feet |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Hi/Lo Blood Pressure | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Stiff joints | <input type="checkbox"/> Tendonitis |

List any 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 _____

Stress levels: Work: (L) 1 2 3 4 5 (H) Home: (L) 1 2 3 4 5 (H)

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 _____