

Welcome to Sydney Stretch Therapy

Private Session



CHERIE
SEETO

Your details

Full name:

Address:

Email:

Mobile:

Date of birth (dd/mm/yyyy):

How did you hear about Stretch Therapy?

What are you hoping to achieve out of this session?

About you & your history

List any injuries, illnesses or surgeries:

Are you still under a physician's care?

Y N

List all current medications, painkillers and supplements:

Do you have frequent or chronic pain?

Y N

If yes, please provide details like when it started, how, where and when it got worse:

List any weekly exercises, type and duration:

List what you eat in a typical day:

Water intake per day:

Coffee/tea per day:

Juice per day:

Alcohol per day:

How do you prefer to sleep? On your:

- Back Side Stomach

How many pillows do you use?

How many hours of sleep are you getting per night?

Below are series of health symptoms. Please check any that apply to you:

- Headache/migraine
- Neck pain
- Shoulder and arm pain
- Back pain
- Leg pain
- High/Low BP
- Bruise easy
- Allergies
- Other (please specify):

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:

Please print, sign and hand this form to Cherie at your first private session.