MUSCULAR BALANCE
MYOTHERAPY

MEDICAL HISTORY

Name: _____

Address: _____

Suburb: _____ Postcode: _____

Phone (M) _____ (H) _____(B) _____

E-mail: _____ Date of Birth _____

Occupation: _____ Hobbies/Sports: _____

How did you hear about us? _____

Medical Condition(s)

Do you have or ever had any of the following conditions? (Please tick)

Stroke, Blackout or TIA		Chest pain		Headaches	
Poor Circulation		Heart Disease		Migraines	
Varicose Veins		Asthma		Nausea	
Thrombosis / clots		Diabetes		Arthritis	
Breathing diffciculties		Dizziness		Skin Disorders	
High/low blood pressure		Osteoporosis		Pregnant	

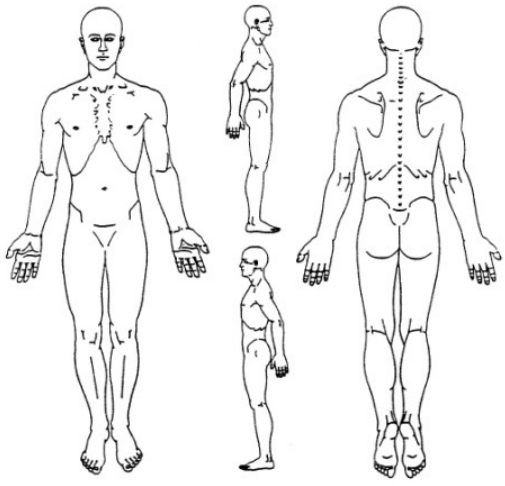
Are you taking any medication? (If yes, please list them) : _____
_____

Briefly, what are your main reasons for seeking treatment today (e.g. low back pain, headaches etc)?_____
_____
_____
_____

Have you had any previous investigation for this complaint (i.e. X-ray, CT scans)? _____

Have you had any treatment for this condition? What type?
_____
_____

Is there anything else we should know?
_____
_____
_____



Cancellation Policy: Please note that a cancellation fee will apply if less then 24hours notice is given

Signature: _____ Date: _____