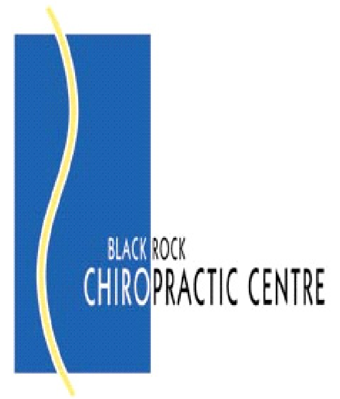
MYOTHERAPY PATIENT INFORMATION



To enable us to assist you in reaching your health goals please complete the following.

Date: ………………. Phone: (h) …………………

Name: ……………………………………………………. (m) ………………..

Address: …………………………………………………. (w)………………….
……………………………………………….. Email:………………………………

Birth date: ………………….. Age: ……………

Occupation: …………………………………………….

Who referred you to this centre: …………………………………….

What is your reason for consulting this office:
……………………………………………………………………………………………
……………………………………………………………………………………………
………………………………………..

When did this problem begin: ………………………………..

On a scale of 1-10 (10 being the worst), how bad is this condition:

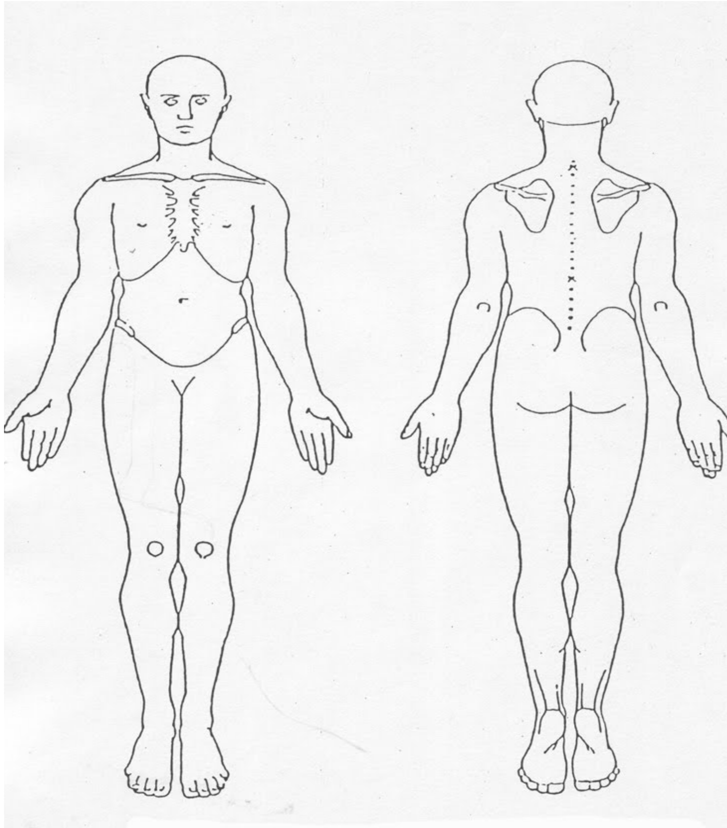
1…………………5……………………10

What aggravates the complaint:
………………………………………………………………………..

What relieves this complaint:
………………………………………………………………………………

Have you ever had this complaint before: ……….

Please indicate the area of concern on the diagram below:



Have you/ are you being treated for any other health condition in the past year: ……

Please list any operations you have had in your life: ……

Do you suffer from any illness (Depression, Fibromyalgia, Parkinson's etc): ……

Are you taking any medication: ………………………………………………….

Have you ever been in a motor vehicle accident: ……………………………………………

GPs name: …………………………………..

Address: ……………………………………………….……………………

Phone: …………………………………………
Do you have Health Insurance: …………………

Name of Fund: …………………………………..

Are you covered for Myotherapy/Remedial Massage: …………………………..

Have you had Myotherapy before: ………………………………………………

In a few short words, please tell us what you think Myotherapy is:
……………………………………………………………………………………
……………………………………………………………………………………
…………………………………………

Have you experienced any of the following before?

- □ Dry Needling
- □ Massage
- □ Yoga
- □ Personal Training
- □ Chiropractic
- □ Chinese Medicine
- □ Acupuncture
- □ Cupping
- □ Pilates
- □ Physiotherapy
- □ Osteopathy
- □ Naturopath

Please indicate your health objectives to us:

- □ Relief of my symptoms
- □ Correct my underlying problems
- □ Maximise my health
- □ Maximise myself and my families health

Please rate your overall health out of 10 (10 being the best possible):

1…………………………………….5………………………………………………10

Where would you like your health to be:

1…………………………………….5………………………………………………10

Signature……………………………………..

Thank you for taking the time to fill this information out, we now look forward to helping you achieve the above goals!