Date of first visit:

DEMOGRAPHICS:

Name:		**Date of Birth:**
Home Address:		
Telephone (home):		**Mobile:**
Email:		
Emergency Contact:		**Telephone:**
Medical Doctor:		**Telephone:**
Referral from:		**Telephone:**

GENERAL:

Height:		**Weight:**
Marital Status:		**Children:**
Occupation:		
Dexterity:	☐ Right handed ☐ Left handed ☐ Ambidextrous	

FAMILY MEDICAL HISTORY: Please tick all that apply

	Yes	Description	Family Member
Cancer			
Depression			
Diabetes			
Gastrointestinal or stomach problems			
Heart problems			
High blood pressure			
High cholesterol			
Respiratory problems (eg. asthma)			
Stroke			
Other (please specify):			

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PERSONAL MEDICAL: Please tick all that apply

TYPE	Yes	TYPE	Yes
Anaemia		Herpes	
Arthritis		High / Low blood pressure	
Asthma		High cholesterol	
Blood Clots		HIV / AIDS	
Circulation problems		Kidney problems	
Concussion		Missing any paired organ	
Constipation (frequent)		Glandular Fever (Mononucleosis)	
Depression		Nosebleeds (frequent)	
Diabetes		Numbness, burning or stinging sensations	
Diarrhoea (frequent)		Osteoporosis	
Earache (frequent)		Pelvic inflammatory disease	
Epilepsy / Seizure Disorder		Pneumonia	
Fatigue (recurring or chronic)		Recurring anxiety	
Frequent Colds, Sinusitis, Chest Infection (3/year)		Scoliosis (curved spine)	
Gastrointestinal or stomach problems		Sinusitis	
Haemorrhoids or Incontinence		Stroke	
Headache (severe or recurring) or Migraine		Thyroid problems	
Hearing difficulty		Tonsillitis, frequent	
Hepatitis or liver problems		Unusual bleeding or bruising	
Hernia		Urinary (bladder) infection (frequent)	
Other (list):			

Childhood Illness if not included above: Please specify below

Are you pregnant? ☐ **Yes** ☐ **No** **If Yes, when are you due?**

INJURIES:

Date of injury	**Body Part**	**Type of injury** (eg: strain, sprain)	**Description of Treatment** (eg: ultrasound, ice, taping, massage)	**Health Professional** (eg: physiotherapist, Dr)

SURGERIES / HOSPITALISATIONS:

Have you ever had surgery? ☐ **Yes** ☐ **No** **Have you ever been in hospital?** ☐ **Yes** ☐ **No**
If yes, please provide details below

Date	**Area**	**Reason / Description of Procedure**	**Surgeon/ Hospital**

DIAGNOSTIC TESTING:

In the last 10 years have you had an x-ray, MRI, CT Scan or other diagnostic test? ☐ **Yes** ☐ **No**
If yes, please provide details below

Date	**Area**	**Reason / Description of Procedure**	**Type of test**

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ALLERGIES:

Do you have any allergies? ☐ Yes ☐ No If yes, please provide details below	
Allergy	**Symptom**
Do you carry an EpiPen?	☐ **Yes** ☐ **No**

MEDICATIONS:

Are you currently taking, or have you recently taken, any prescribed or over the counter medications, supplements, natural products including herbs? **Please list below**

Name of Medication	Reason	Dosage	Date Medication Started

DENTAL HISTORY:

Last dental exam:		
Have you had your wisdom teeth removed? If yes, date of removal:	Yes	No
Do you currently have problems with your teeth/gums? If yes, please explain.	Yes	No
Do you have any crowns or implants?	Yes	No
Do you wear dentures?	Yes	No

VISION HISTORY:

Do you wear glasses?	Yes	No
Do you wear contact lenses?	Yes	No
Have you had corrective eye surgery? If yes, please provide detail.	Yes	No
Have you had any eye injuries or problems for which you sought medical care? If yes, please provide detail.	Yes	No

DERMATOLOGY HISTORY:

Do you have problems with your skin eg eczema, psoriasis, skin cancer?	**If yes, please provide details:**		
Have you seen a dermatologist (skin doctor) recently? If yes, when?		Yes	No
Have you ever had any moles removed?		Yes	No
Do you wear 30 SPF or greater sunscreen on your face and body?		Yes	No

LIFESTYLE HABITS: (Please provide details)

Sleeping patterns (eg: how many hours / night; wake up rested)		
Eating Habits (eg: # meals /day - balanced diet)		
Special dietary requirements		
Hydration	Water: # glasses per day	Coffee, Tea, Caffeine drinks: # per day
Do you drink alcohol: ☐ Yes ☐ No **How many / day:**	**# drinks / week:**	
Do you smoke: ☐ Yes ☐ No	**Do you use recreational drugs:** ☐ Yes ☐ No	
Do you exercise regularly? How often? At what level?		

During or after exercise, or at any other time, have you ever?

Felt dizzy or light-headed? Had chest pain or tightness? Had racing, irregular, or skipped heart beat? Had difficulty breathing? Had excessive fatigue?				Yes	No
If yes to any of the above, please explain:					
Have you had any blood tests in the last year?	Yes	No	Have you *ever* had any abnormal results with blood tests?	Yes	No
If yes, please specify date and description:					

OCCUPATION:

How long have you been in your current job?	How many hours do you work a week?
Is your job stressful? ☐ Yes ☐ No	

What do you like to do to relieve stress?

PRESENTING CONDITION:

SYMPTOMS:

Previous occurrence of presenting complaint:

Previous treatment for current complaint and response to treatment:

Type of Treatment (eg: Physiotherapy/Osteopathy)	**Response to treatment received:**

What are your goals from this treatment session?

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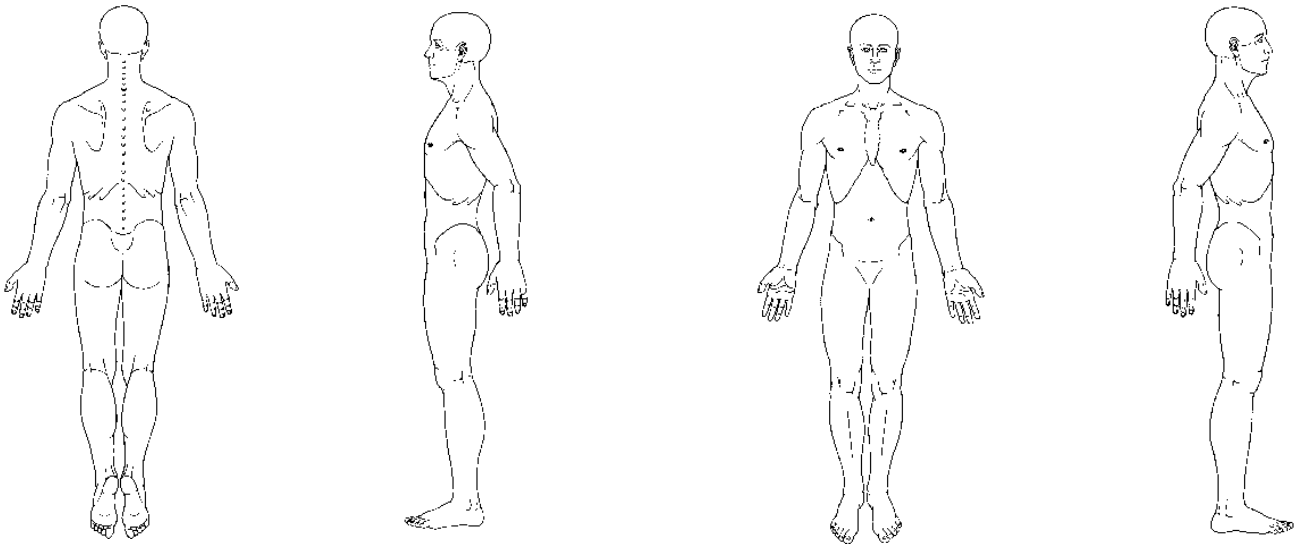
THERAPIST USE ONLY

Observation & Palpation of Posture (include major areas of asymmetry pain tension & tone)



REGIONAL EXAMINATION Assessments should be performed at initial consultation

NB: Members are advised that some States and Territories Legislation may prohibit these tests being performed due to the scope of Allied Health providers. Please check relevant Legislation in your State or Territory and ensure you apply only what you have been trained in and that you act within your Scope of Practice, the Massage & Myotherapy Code of Ethics and the National Code of Conduct for Health Workers.

Area	Active ROM	Pre treatment	Result (+ve / -ve)	Post treatment	Result
	Passive ROM	**Pre treatment**	**Result (+ve / -ve)**	**Post treatment**	**Result**
	Resisted Test	**Pre treatment**	**Result (+ve / -ve)**	**Post treatment**	**Result**

Special Tests: refer to list attached (appendix 1)					
Area	**Active ROM**	**Pre treatment**	**Result (+ve / -ve)**	**Post treatment**	**Result**
	Passive ROM	**Pre treatment**	**Result (+ve / -ve)**	**Post treatment**	**Result**
	Resisted Test	**Pre treatment**	**Result (+ve / -ve)**	**Post treatment**	**Result**
Special Tests: refer to list attached (appendix 1)					

Area	**Active ROM**	**Pre treatment**	**Result (+ve / -ve)**	**Post treatment**	**Result**
	Passive ROM	**Pre treatment**	**Result (+ve / -ve)**	**Post treatment**	**Result**
	Resisted Test	**Pre treatment**	**Result (+ve / -ve)**	**Post treatment**	**Result**

Special Tests: refer to list attached (appendix 1)					

Gait Analysis:

Safety Issues/Contraindications:

Red Flags	**YES / NO**	
Further Investigations Required	**YES / NO**	
Referral Required	**YES / NO**	

Possible Risks and Complications – advice given to client

Treatment Goals & Proposed Treatment

Evaluation of Treatment

What adaptions to the treatment will you make for any presenting pathological conditions?

Re- Assessment Findings – first return visit

Ongoing Treatment and Aftercare

Home Advice:
Exercise Plan:
Stretching Plan:

Appendix 1 Special Tests that can be included, but not limited to, are;

Cervical	**Results**
Empty can test	
Cervical Compression test	
Cervical Distraction test	
Thoracic Outlet test	
Hautant's Vertebral Artery test (VAO)	
Shoulder	
Impingement testing (eg Neers)	
Thoracic Outlet test	
Hawkins Impingement test	
Empty can test	
Speeds or Yergasons	
Apley's Scratch test	
Elbow Wrist and Hand	
Varus/Valgus stress test	
Lateral and Medial epicondyle test	
Tinels / Phalens test	
Thoracic	
Slump test	
Thoracic Outlet Test	
Lumbar	
Valsalva	
Pelvic Symmetries ASIS/PSIS	
Straight Leg Raise	
Lumbar Quadrant test	
Pelvic	
Thomas test (modified)	
Patrick or Faber test	
Obers test	
Leg length test	

Stork or Gillet test	
Trendelenberg Sign	
Knee	
ACL drawer test	
ACL Lachman test	
Patella apprehension test	
TA rupture Thompson test	
Ankle and Foot	
Ankle ligament anterior drawer test	
Lower Limb Squat	
Comments:	

Consent for Treatment I understand that:

- This is a myotherapy treatment and is not a medical or allied health treatment (physiotherapy, osteopathy, chiropractic)
- I have viewed the therapists' qualifications
- The risks specific to my individual circumstances may have a bearing on my decision to proceed with the proposed treatment
- The therapist reviewed my health history before treatment commenced
- The therapist explained that the physical assessment I received may involve partial undressing and may require the therapist to palpate (touch) the area(s) of my body relevant to my presenting condition
- The therapist explained the treatment options to me and gave me choice
- The therapist explained the associated risk and possible side effects with the treatment options as described
- The therapist discussed the treatment procedures, the areas of the body to be treated, the undressing and dressing procedures, the draping procedures and the positioning on the table for and during treatment
- The therapist established that the treatment session will be stopped should the treatment as first agreed to, require modification. The therapist will explain the reason for the change and any risks and/or side effects as a result of the change
- I can ask any questions in regard to any modification to the treatment plan. I should be totally comfortable with the explanation and reasoning for the change before consenting to the modification to the initial treatment plan
- The therapist has explained that I have the right to refuse treatment, to make changes to the treatment and to stop the treatment session at any time
- I have the right to request evidence for treatment that may include the abdomen, anterior and lateral chest, and buttock and / or groin areas. I understand I have the right to refuse treatment of these areas
- If I agree to treatment to any of the areas mentioned in the point above, I may be requested, by the therapist, to complete a consent form relevant to those areas

Only sign below if the above information is understood and has occurred

Client
Name:_____ Signature:_____
Date:_____

Parent/Guardian
Name:_____ Signature:_____
Date:_____

Therapist
Name:_____ Signature:_____

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Date:_____