inner outer health®

CLIENT FORM

❑ Dr | ❑ Mr | ❑ Miss | ❑ Mrs | ❑ Ms		
Surname		
First Name		Date of Birth
Street Address		
City/State		P/Code
Home #	Business #	Mobile #
Email address		
Occupation		
What is your primary reason for seeking myotherapy treatment?		

EXISTING OR PAST CONDITIONS		
Allergies		
Communicable diseases		
Current medical treatment/medication		
Nutritional supplements		
Skin diseases		
SURGERY	Date	Type
Current Symptoms		
INJURY	Date	Type
Current Symptoms		

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CURRENT HEALTH / MEDICAL CONDITIONS

Please tick if you are currently experiencing any of the following:

❑ Rheumatoid fever	❑ Heart/Circulatory problems	❑ Kidney disease
❑ Bone disease	❑ Diabetes	❑ Stroke
❑ Bouts of dizziness	❑ Osteoporosis	❑ Asthma
❑ Gastric ulcer	❑ Arthritis	❑ Cardiac pacemaker
❑ Malignancies (cancer)	❑ Cholesterol	❑ Excessive bleeding
❑ Spinal disorder	❑ Epilepsy	❑ Steroid medication
❑ Pregnant	❑ Other	

HEALTH FUNDS

Do you belong to a health fund? ❑ YES | ❑ NO

If yes, name the health insurance fund

A LITTLE MORE ABOUT YOU

Do you play **sport** or are you involved in any other **physical activities?** If so, what?

Are you a member of any health/sport/fitness clubs? If so, please specify

HOW DID YOU HEAR ABOUT US?

Please tick all that apply

❑ Family	❑ YouTube	❑ Google (what words did you google?)
❑ Friend	❑ Yellow pages	_____
❑ Partner	❑ Newspaper	_____
❑ Work	❑ Magazine	_____
❑ Doctor	❑ Natural therapy pages	_____
❑ Internet	❑ White pages	
❑ A-frame		❑ Other (please specify)
❑ Gift voucher		
❑ Advertising	Which website did you visit?	_____
❑ Signage	❑ InnerOuterHealth.com.au	_____
❑ Driving past	❑ FloatationTankMelbourne.com.au	_____
❑ Social media		_____

CANCELLATION POLICY

A cancellation fee of 50% of the session fee may be charged if you cancel with less than 24 hours notice. If you fail to arrive for your session, you will be charged the full price for your missed appointment.

I declare that the information I have provided on this form is complete and correct and that I will notify Inner Outer Health Pty Ltd if any changes occur. I authorise a responsible member of Inner Outer Health to drive me to a clinic or hospital if treatment may be deemed necessary. If treatment is required, then the cost is the responsibility of me.

Signature	Date