Bergamo & Associates
Chiropractic & Nutrition Centre

340A Boronia Road
Boronia, Victoria 3155
Fax: 9887 4343
Email: info@bergamohealth.com.au
Website: www.bergamohealth.com.au
Tel: 9887 4144

"Listening, Caring and Enhancing Health"

MYOTHERAPY/REMEDIAL MASSAGE NEW PATIENT FORM

Mr ☐ **Mrs** ☐ **Ms** ☐ **Miss** ☐ **Master** ☐ **Other**___________

First Name: .... **Surname**... **Date**: ..../......./.........

Address: .... **Suburb**...................... **Postcode**......... **DOB:** ....../....../..........

Phone no: Home: .... **Work**... **Mobile**:..

E-mail .... **Partner/Spouse**: .... **No. of Children**: ....

Occupation: .... **Who recommended you to this centre**? ....

Medical Doctors Name .... **Medical Centre Name** ....

Are you responsible for this account? ☐ Yes ☐ WorkCover ☐ TAC ☐ Veterans

Do you have private health coverage? Yes/No If yes, which fund ....

Emergency contact .... **Phone number** .... **Relationship**..............................

ABOUT YOUR HEALTH

1. **Why are you here?** ....

2. **Have you seen a Myotherapist/Remedial Massage therapist? (please circle) If so, please answer the following:**

My previous experience of Myotherapy/Massage was:	Poor	Average	Excellent

3. **Have you ever been diagnosed as having any of the following?** **C = Current P = Past**

	C	P		C	P		C	P
Fractures			High/Low Blood Pressure			Metal implants/plates/screws		
Hospitalization			High/Low Blood Glucose			Lung conditions e.g asthma		
Surgery			Heart problems			Blood disorders		
Incontinence			Epilepsy			Rheumatoid arthritis		
Regular headaches/migraines			Osteoporosis			Thyroid dysfunction		
Allergies/food intolerances			Unexplained weight loss			Stroke		
Diabetes			Cancer			Anaemia		
Neurological conditions			Kidney disease			Multiple Sclerosis		

4. **a. Do you smoke?** Yes / No **b. Do you drink?** Yes / No

5. **Now or in the past have you ever experienced any of the following:** **C = Current P = Past**

	C	P		C	P		C	P
Dizziness/light-headedness			Being knocked unconscious			Pins and needles or numbness		
Fainting or blackouts			Pain waking you at night			Pain on coughing/sneezing		

6. **Are you, or could you be pregnant?** Yes / No

7. **What are three things you can't do because of your pain in the last week?**

   1. .... **2.**.. **3.** ....

8. **What are three health goals you would like to achieve, and in how long?**

   1. .... **2.**... **3.** ....

"Listening, Caring and Enhancing Health"

Bergamo & Associates Chiropractic & Nutrition Centre

340A Boronia Road
Boronia, Victoria 3155
Fax: 9887 4343
Email: info@bergamohealth.com.au
Website: www.bergamohealth.com.au

Tel: 9887 4144

9. **List your current medications/supplements below**

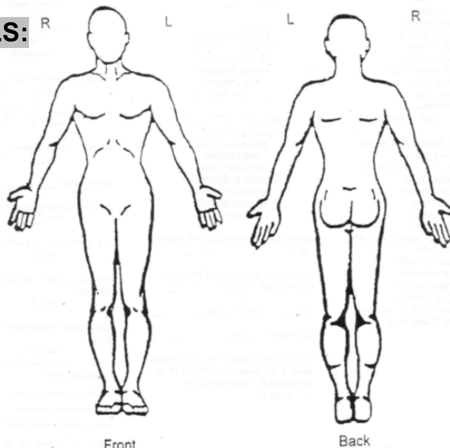
………

MEASURING YOUR PAIN LEVELS:
Please label the diagram to the right with the following:

Pain: ####

Numbness: oooo

Pins/Needles: xxxx



Please circle your *current* pain levels

No Pain — Unbearable Pain

1	2	3	4	5	6	7	8	9	10

Please circle your *worst* pain levels in the past week:

No Pain — Unbearable Pain

1	2	3	4	5	6	7	8	9	10

MEASURING YOUR WELL-BEING LEVELS:
Please rate the following with respect to frequency over the last week by circling the most appropriate

	Never	Rarely	Occasionally	Regularly	Constantly
How often do you have neck pain?	0	1	2	3	4
How often do you have headaches?	0	1	2	3	4
How often do you feel dizzy or light-headed?	0	1	2	3	4
How often do you have back pain?	0	1	2	3	4
How often do you have shoulder/elbow/wrist/hand pain? (please circle)	0	1	2	3	4
How often do you have hip/knee/ankle/foot pain? (please circle)	0	1	2	3	4
How many times do you exercise per week?	4	3	1	0	0
How often do you feel fatigued or have low energy levels?	0	1	2	3	4
How often do you experience depression or lack of interest?	0	1	2	3	4
How often do you have difficulty falling asleep or staying asleep?	0	1	2	3	4

Score: /40

INFORMED CONSENT Myotherapy and Remedial Massage has proven to be safe and effective, however with any form of healthcare, no-one can guarantee results. There are also rare, yet potential adverse effects that may occur; including (but not limited to) post treatment pain, bruising, bleeding, sleepiness, fainting or aggravation of your condition. These potential risks and complications cannot be predicted, however are easier minimised/avoided by thoroughly answering this confidential form. You have the right to refuse treatment or to stop treatment at any time. Please communicate with the practitioner, and advise the therapist if you have any points of concern, for example: “please do not treat my face/ears/stomach etc.”, or “I do not wish to remove my t-shirt” or “I have a skin allergy to a certain cream/oil.” We comply with the Privacy Act, and will not share your information with any third party without your permission.

CANCELLATION POLICY The clinic is a very busy clinic. Often we have to place patients on a waiting list as they cannot have their first preference appointment. If a patient cancels an appointment, without a reasonable explanation and within 24 hours of their appointment, the centre will bill a Cancellation Fee of $25.

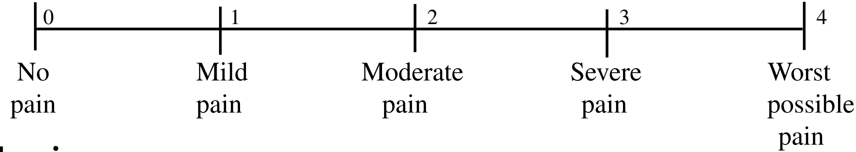
DO NOT SIGN the following until you have spoken with your Myotherapist/Remedial Massage therapist:
I understand the above, have been given the opportunity to ask questions and have been satisfied with the answers.
Having discussed and understood the practitioners recommendations, I grant permission for care to proceed.
I understand I can withdraw this permission at any time.
Patient’s signature:……………………………………………………………..…………… Date……………/………/………..
(Parent or Guardian if patient under 18)
Patients Name (Please print) …………………………………………………………Practitioners signature…………………..

Functional Rating Index

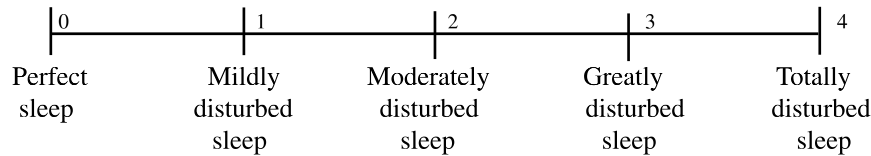
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

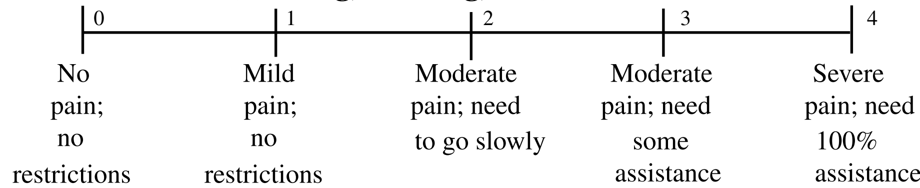
1. Pain Intensity



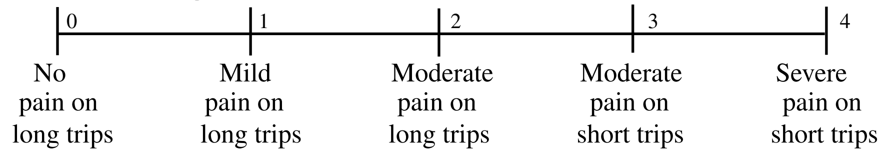
2. Sleeping



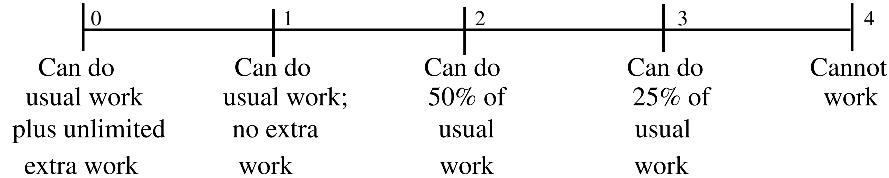
3. Personal Care (washing, dressing, etc.)



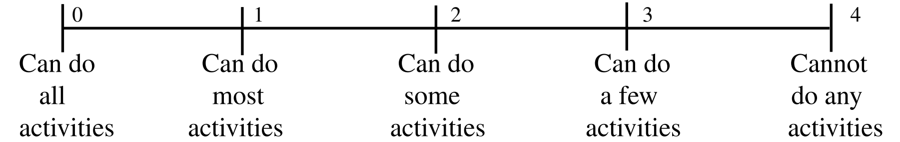
4. Travel (driving, etc.)



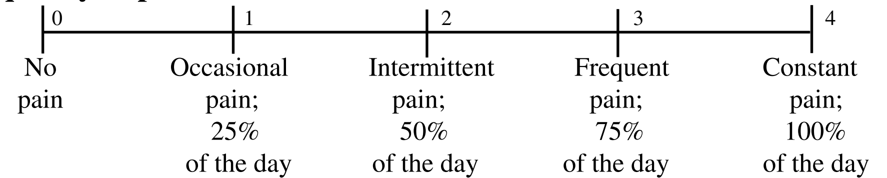
5. Work



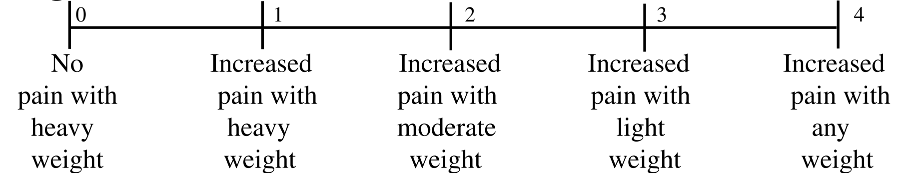
6. Recreation



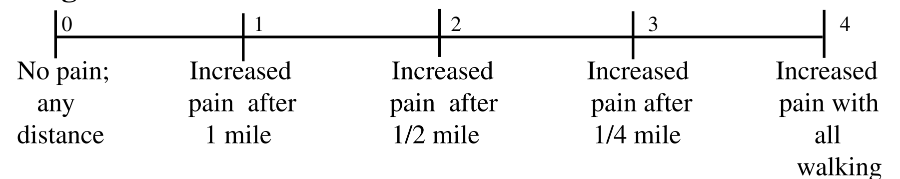
7. Frequency of pain



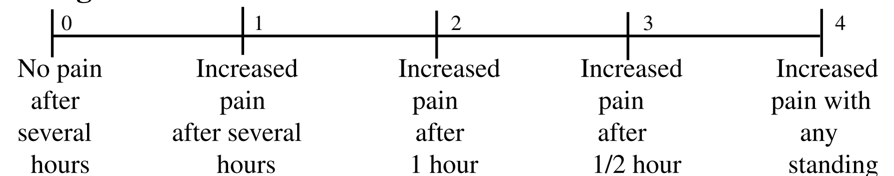
8. Lifting



9. Walking



10. Standing



Name ______________________________

PRINTED

____

Signature

____

Date

Total Score __________

© 1999-2001 Institute of Evidence-Based Chiropractic