Confidential New Client Registration Form

Date:_____________

Name: ____ Date of Birth: ___/___/___

Address:____

____ Postcode_____________

Occupation:____________________________ Phone: __________________________

Email: ____

Main Area of Concern : ____

Hours per day seated:

Driving / Travelling: _______

Sitting at a desk/meeting/PC: _____

Watching TV: __________

What exercise / activity do you do?

____

____

____

How often do you exercise? Daily ☐ A few times a week ☐ Occasionally ☐ Never ☐

Stress levels: ☐ Very High ☐ High ☐ Medium ☐ Low

How would you describe your overall health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Known Allergies: ________________________

Are you currently receiving other therapy or treatment? ☐ Yes ☐ No

☐ Chiropractic Care ☐ Physiotherapy ☐ Osteopathy ☐ Pilates ☐ Yoga ☐ Medical

Relevant Medical History / details of injuries, pain or discomfort.

____

____

____

____

____

____

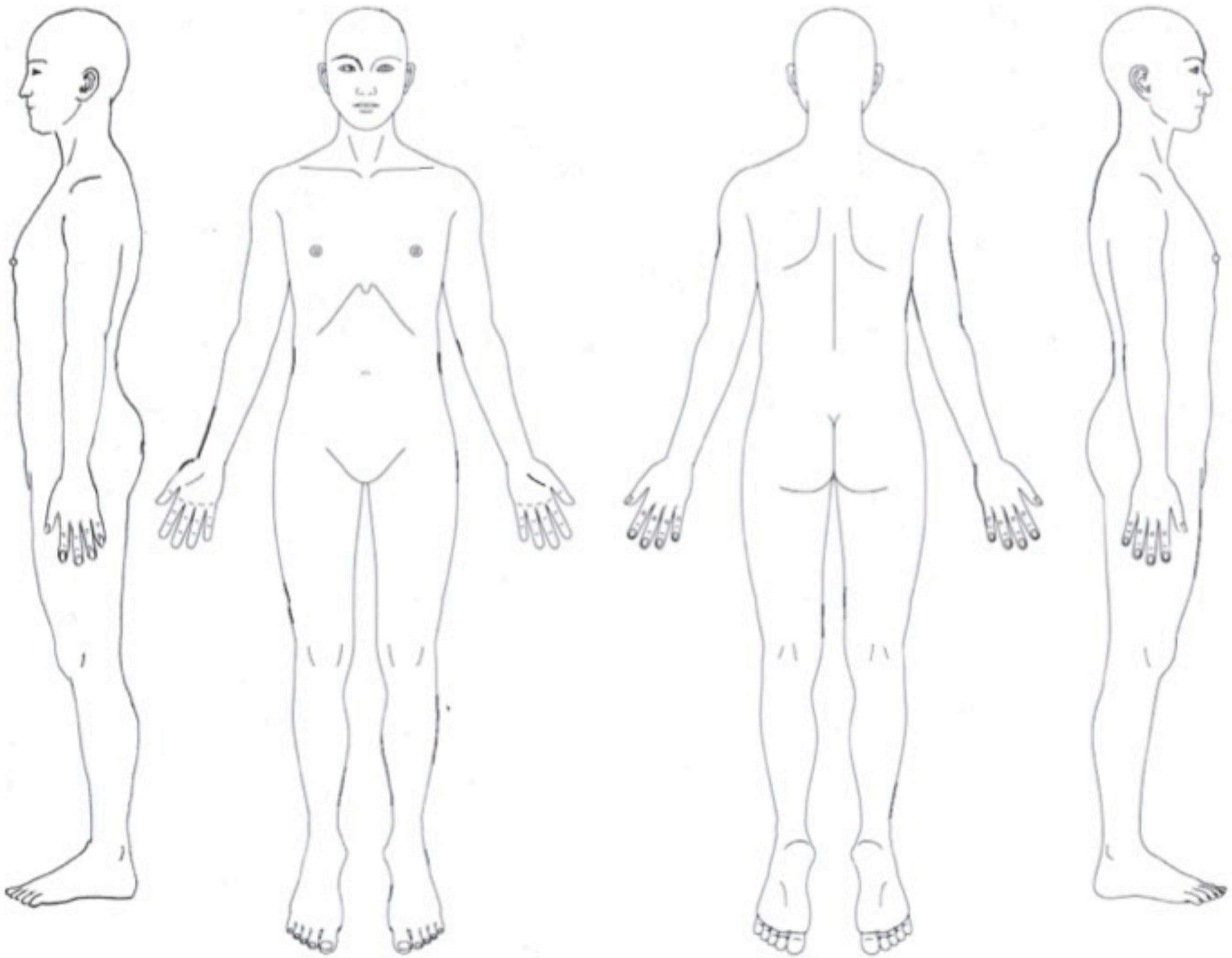
____

____

____

Please turn over

Please indicate on the image below where you have any injuries or feel pain or any discomfort. Thank you.



DECLARATION: This information is accurate to the best of my knowledge and I hereby consent to massage treatment.

Client Signature: ___________________________________

Post treatment notes: