Trina Bailey Healing
Connecting · Nurturing · Transforming

Confidential Client Information Form

Please answer all of the questions included in this questionnaire. Please note that Trina meets regularly with colleagues and mentors for professional development purposes as a requirement of her registration. While your identity and confidentiality are maintained at all times, aspects of your treatment plan and care may be discussed with others to assist Trina in providing a better service to you.

Personal Details

Title ______________________

First name ______________________

Surname ______________________

Street address ______________________

Suburb ______________________

State ____________ Postcode ____________

Postal address ______________________

Suburb ______________________

State ____________ Postcode ____________

Email ______________________

Home phone ______________________

Work phone ______________________

Mobile ______________________

How would you like to be contacted if needed?

- ☐ Mobile phone
- ☐ Work phone
- ☐ Home phone
- ☐ Email

Date of birth ______________________

Occupation ______________________

Emergency contact name ______________________

Emergency contact phone ______________________

Current doctor ______________________

Do you have health insurance for remedial massage/therapy?

☐ Yes ☐ No

Who is your health fund provider? ______________________

How did you hear about Trina Bailey Healing?

____

____

What is the reason for your visit?

____

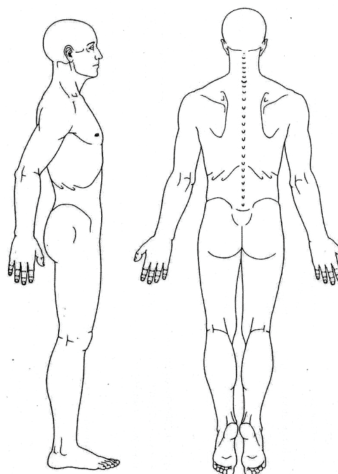
____

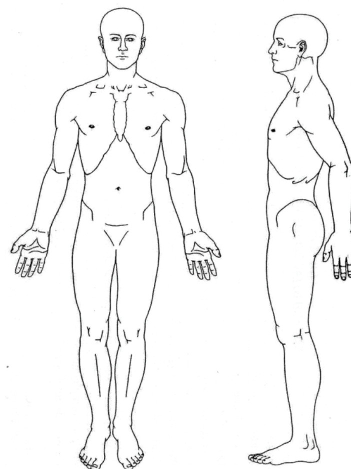
What are your expectations and/or goals?

____

____

Please mark on the figures below, any areas of pain or discomfort you are experiencing.





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Client Information Form cont.

General Information

Have you had a massage before?

☐ Yes ☐ No

If yes, please specify:

Have you ever had surgery?

☐ Yes ☐ No

If yes, please specify:

Do you have any diagnosed conditions, injuries, or previous broken bones?

☐ Yes ☐ No

If yes, please specify:

Are you currently taking any medications or supplements?

☐ Yes ☐ No

If yes, please specify:

Are you allergic or sensitive to any base oils (often nut based), creams or essential oils?

☐ Yes ☐ No

If yes, please specify:

Please indicate if any of the following are relevant to you:

- ☐ Allergies
- ☐ Skin conditions
- ☐ Contagious conditions (Tinea etc.)
- ☐ Cold/flu/fever
- ☐ Headaches/migraines
- ☐ Numbness/tingling
- ☐ Sleeping problems
- ☐ Pregnancy
- ☐ High/low blood pressure
- ☐ Diabetes
- ☐ Blood/heart conditions
- ☐ Bruising
- ☐ Infectious diseases (HIV, Hep C etc.)
- ☐ Arthritis
- ☐ Cancer
- ☐ Asthma
- ☐ Varicose vein/deep vein thrombosis
- ☐ Epilepsy
- ☐ Brittle bones
- ☐ Sciatica
- ☐ Chronic pain or fatigue
- ☐ Joint replacement
- ☐ Neck/spinal/back conditions (eg whiplash, scoliosis, spinal fusion etc)

Do you have any other conditions relevant to your treatment?

☐ Yes ☐ No

If yes, please specify:

Are you currently seeing any health care or medical practitioners for treatment?

☐ Yes ☐ No

If yes, please specify:

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Client Information Form cont.

General Information cont.

What do you do for recreation (activities/hobbies/exercise)?

____

____

____

How would you rate your overall stress level at this time?

☐ Low ☐ Medium ☐ High

Have you recently experienced a high level of stress?

☐ Yes ☐ No

If yes, please specify:

____

____

____

Do you wear contact lenses?

☐ Yes ☐ No

Female Clients Only

Are you pregnant or trying to get pregnant?

☐ Yes ☐ No

If yes, how many weeks? ______________

How many pregnancies have you had? ______________

Client Agreement

Thank you for completing this questionnaire. Please sign, date and return (post, email or bring to your first appointment) this Client Information Form to Trina after you have read the following Terms and Conditions carefully:

- ☐ I understand that 24 hours notice is required when altering appointments.
- ☐ I understand that a fee of $35 will be charged when less than 24 hours and more than 3 hours notice is given.
- ☐ I understand that the full fee will be charged when an appointment is missed, or when 3 hours or less notice is given.
- ☐ I am aware that Trina may discuss aspects of my treatment plan with peer mentors and professionals in order to improve her service to me.
- ☐ I agree to keep Trina updated with changes that impact on my wellbeing and which may affect my treatment plan.
- ☐ I agree to inform Trina of any pain or discomfort I experience during my treatment to allow the treatment to be modified to suit my needs.
- ☐ I confirm that the information I have disclosed in this questionnaire is true and correct.

____

Signature Date