Welcome to Healing For Success

So that your Therapist can provide you with the most appropriate and comprehensive holistic treatment possible, please complete this Client History and Consent Form as honestly as possible.

Your Therapist appreciates that some of these questions are of a very personal nature, however, these questions are not meant to be intrusive but rather information gathering to provide us with an insight as to what stresses you face which may be having a causal affect or impacting any symptoms that you may be experiencing. Your Therapist will then be able to design a holistic comprehensive treatment plan specifically for you.

All information provided is treated and stored with complete confidentiality as per Australian Privacy Laws.

Title (Miss, Mrs, Mr etc)	Surname
First name	Preferred name
Address post code	
Mobile Ph	Email
Date of birth	Occupation
Emergency contact person: Phone:	

Name of your normal Doctor ……

Address …… Phone……

How did you hear about us? __Family __Friend __Website __Social Media __Google __Other……..…...

What is the main problem you would like us to help you with?

Overall fatigue / Just feeling out of sorts / Stressed out / Grieving / Muscle Pain / Joint Pain Restricted movement / Pampering / Relaxation / The works!

Other ..…….……..

Pre-Assessment Questionnaire for ALLTherapies

Please tick all conditions that apply right now. Put a "P" for past conditions.

__pain neck/jaw	__pain back	__pain shoulder/arm/hand
__pain hip/leg/foot	__pain at night	__tingling arms/hands
__tingling legs/feet	__numbness arms/hands	__swelling legs/feet
__swelling arms/hands	__weakness/clumsiness	__loss of balance
__headache/migraine	__dizziness/light headed	__ heavy headed
__fainting		__blurred vision
__speech impairment	__loss of smell/taste	__fatigue
__tension/stress/anxiety	__irritability/nervousness	__sleeping problems
__depression/PTSD	__loss of memory	__convulsions/seizures
__skin rashes	__skin itching	__skin wounds
__skin infections (eg tinea)	__bruise easily	__pain when cough/sneeze
__sinus problems	__asthma	__high blood pressure
__low blood pressure	__varicose veins	__blood clots/DVT
__stroke CVA	__digestive issues	__stomach upsets/ulcers
__constipation	__diarrhoea	__diabetes
__cancer/tumours	__fever	__hepatitis
__AIDS/ARC/HIV	__menstrual problems	__pregnant or possibility of
__contraceptive use	__hormone replacement	

Do you have any known allergies or sensitivities? (eg bee products, latex, oils, smells, food, medication etc)

……

What type of therapies have you tried before? (eg massage, physio, counselling etc)

Yes / No If so, what were they and what was the outcome ? ……

Have you had any fractures? Yes / No ……..

If so when/where……

Have you had surgery ? Yes / No ……..

If so, when/why……

Do you have any diagnosed medical conditions? (eg reflux, osteoporosis, PTSD etc)

……

……

Are you currently undergoing any medical testing? (xrays, blood tests etc) YES/NO……..

If so, what for?.....

Rate your *health* at present out of 10 (10 being healthy, 0 being very sick) ……../10

Rate your *fitness level* at present out of 10 (10 being very active, 0 being inactive) …../10

Medication currently being taken (include prescriptions, over the counter, supplements, herbs etc)

……

Do you have a current complaint/problem? YES/NO ……

If so, please advise ……

……..

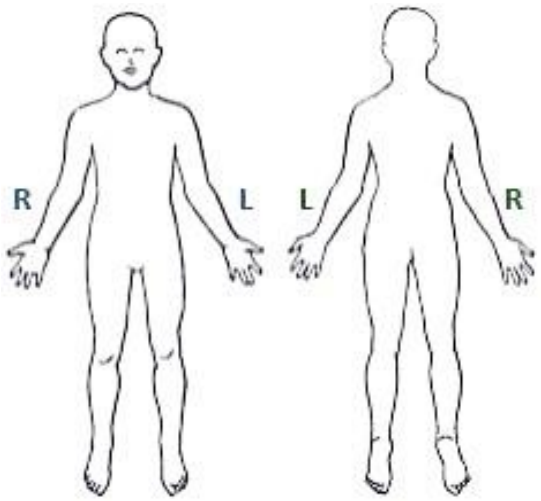
- Do you experience any pain or discomfort with this problem? YES/NO……
- Rate your *pain level* at present out of 10 (10 being severe, 0 being no pain) …../10

- Have you been given a diagnosis for this problem? YES/NO …….. if so, what?……
  ……

- Is this problem interfering with any of the following?

Activities of daily living	Yes	No	How?
Sleep			
Work/study			
Eating			
Social Activities			
Relationships			
Sports/recreational activities			

- Mark on the diagram where your pain is



Tell me a bit about you…

What type of communicator are you?
I am a confident speaker / I speak my mind / I can only take so much before I explode / I bite my tongue to avoid confrontation or rejection; regardless of how I feel

What is your relationship status? Single / Married or Defacto / Separated / Widowed

How long have you been in your current relationship? ……..months/years or Not applicable

How would you judge the health of your relationship with your partner?
Good / Average / Not happy

How would you say your intimacy levels are?
Good / Neither here nor there / Non-existent

Do you have any issues with the following?
Pelvic floor / vaginal dryness / menstrual or menopause / bladder control / bowel control / erectile dysfunction / prostate

Do you have any children? If so, how many? Yes / No ……

Do you have step-children? If so, do they live with your family or with their other parent or guardian?.....

How do you feel when you are in contact with your step children or their other parent?
Good / We have an amicable relationship / Exhausted / Stressed & anxious / I hate it

Are your children or step-children, school aged, unemployed or working, have their own family?
……
……
……

How do you feel about any changes in your immediate family dynamic such as kids growing up & leaving home? Good / Excited for them & myself / Not sure who I am / Depressed

What are your memories of your own childhood like? Positive / Negative

What does your internal dialogue and beliefs sound like? Positive / Negative

Do any members of your immediate family have any injuries or health issues? Yes / No

If yes, please provide a brief description ……
……

How much stress or anxiety does this cause you out of 10? Where 0 is nothing and 10 is stressed through the roof …….. / 10

Are you a carer for someone outside of your immediate family? Yes / No

Does your family experience financial stress on a regular basis? Yes / No

Are you employed? Yes / No Full time / Part time

Do you enjoy you work? Love it / Yes / It's a job / I hate it

Are you comfortable with workplace dynamics? Yes / No

Have you ever experienced or witnessed trauma? (eg car accident, assault, bullying, war service etc) Yes / No ……..…

Please indicate if you resonate with any of the following? (please circle)

Low self-worth Lazy Bad Never finish anything Fluctuating mood Fearful

Weight issues Lack of focus Responsible Isolated Not in control Invincible

Undeserving Sensitive Trapped Accident prone

Rate your *emotional/stress status* at present out of 10 (10 being ecstatic, 0 being depressive within yourself)…../10

Client Agreement and Consent to Treatment

Client Name ……

I understand that there are some risks with any form of care. I have discussed my risks with my therapist, have been given the opportunity to ask questions and am satisfied with the answers. I have been directed to view information about the Tyson Titanium Trust and Tyson Titanium Pty Ltd trading as Healing For Success Company Policies & Disclaimer including services offered at www.healingforsuccess.com.au . I can view the National Code of Practice For Health Care Workers at https://www.health.qld.gov.au/system-governance/policies-standards/national-codeof-conduct/default.asp. I understand that I can choose to cease care at any time. Having discussed and understood the program of care outlined for me, I grant permission for care to proceed.

By completing your details and signing this Client History & Consent Form indicates your agreement to our Company Policies & Disclaimer and the Welcome Letter provided.

Client signed:……..Date:……

Therapist signed:……...……...……Date:……..