Welcome to No More Knots!

To help our staff help you, please tell us about yourself!

Personal Details

(The more details you provide the better we can ensure you are looked after at No More Knots)

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Address: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

_ _

Phone (H): _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Mobile (M): _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Work (W): _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

DOB: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Occupation: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Health Fund: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

We aim to provide you with the highest level of customer service. Email is the best way to communicate with your therapist and we ask that you please provide your email address below to ensure you get the best possible service.

Email: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

How did you find out about No More Knots?

(We value referrals and reward current clients for referring others to us so **PLEASE TELL US WHO!!**)

Another Client (Who?) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

GOOGLE Search ☐

What words did you search _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Signage/Driving Past ☐

Physio/Chiro/GP referral (Who?) _ _ _ _ _ _ _ _ _

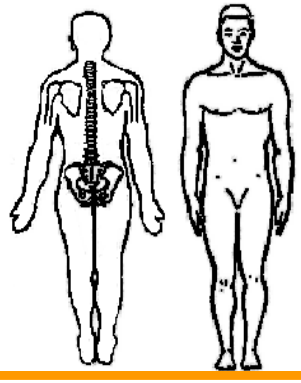
Other (Please specify): _ _ _ _ _ _ _ _ _ _ _ _ _ _

_ _

_ _

Where are you sore?

Don't worry if you have to circle the entire picture– we're here to help!



Some Specifics..... We want your experience to be the best it can be!!

Please indicate what pressure you prefer

Firm Medium Gentle

Please let the girls on Reception know if you would prefer a Quiet Room.

**While quiet rooms are limited, we will endeavour to accommodate you where ever possible.*

Please read the following statements carefully & sign & date in the spaces provided.

- I agree that the above information is true and correct. I agree to allow the Remedial Therapist to liaise with other health care professionals if further treatment is required.
- As part of our service to you, we will send SMS reminders & communication for your appointments.
- **Tick if you do not wish to receive email/text re: reminders/ specials/ pricing**

CANCELLATION POLICY

Our therapists work as subcontractors, therefore do not get paid if you do not attend your appointment. We value our staff, so we have a cancellation policy to respect the use of their time .

- **If you need to cancel:** Outside 4 business hours there will be NO CHARGE to your account.
- **If you cancel:** Within 4 business hours 25% of the fee will be charged to your account.
- **If you don 't show up:** You will be billed for 50% of the fee.

I have read and understood the cancellation policy

Signature: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ **Date:** _ _ _ _ _ _ _ _ _ _ _

Your Health & Your Body

Please circle if you have received treatment from any of the below in the past 6 months:

Physio/Chiro/Podiatrist/Other

Are you on any medications? (Please List)

Do any of the following apply to you? (circle)

Allergies	Blood Clots
Cancer	Depression/Anxiety
Dizziness	Diabetes
Headaches/Migraines	Heart Conditions
High Blood Pressure	Infections Conditions
Joint Replacements	Kidney Conditions
Loss of Balance	Neck/Spinal Injury
Numbness	**Pregnancy –**
Recent Accident/Injury	*How many weeks?*
Shingles	Skin Disorders
Sleep Disorders	Varicose Veins

Other – Please specify

Are there any other issues you feel your Therapist should be aware of before the treatment?

Staff Use Only. Entered - YES NO

THERAPISTS USE ONLY

HEALTH HISTORY ASSESMENT FUNDAMENTALS

LOCATION OF PAIN, IS IT LOCALIZED OR REFERRING INTO A BROADER AREA?

ON A SCALE OF 1-10

1 2 3 4 5 6 7 8 9 10

HOW LONG HAS CONDITION BEEN PRESENT?

ACUTE – less than 48hrs

SUB ACUTE – 48hrs – 3 wk

CHRONIC – 3 wks +

WHAT TYPE OF PAIN?
(POSSIBLE indications below)

Cramping/Dull/Aching
(muscular, ligament, joint)
Sharp/Shooting
(nerve root)
Lightening Like, Bright, Electric
(nerve)
Burning, Pressure, Stinging
(sympathetic nerve)
Deep, Nagging, Dull
(bone)
Sharp, Severe, Intolerable
(fracture)
Throbbing, Diffuse
(vascular)
Fuzziness
Broad Pulling/ Broad Burning
(fascia)

WORSE IN THE:

AM

PM

Consistent

ONSET

Gradual

Sudden

DO ANY OF THE FOLLOWING PROVIDE RELIEF?

Panadol

NSAIDS

ICE

Heat

WHAT AGGRAVATES/RELIEVES YOUR CONDITION

Work

Rest

Sleep

Other ROM or activity. Please Note

DO YOU EXPERIENCE?

dizziness/nausea/blurriness in eyes/ ringing in ears?

ROM/PROM/AROM/AAROM Findings

Basic Special Tests to use

VAI (severe h/a's, dizziness) +VE / -VE

SLUMP (LB P, Disc, Facet) +VE / -VE

SLR (LB P, Disc, Facet) +VE / -VE

KEMPS/Spurlings (Facet) +VE / -VE

Standing Forward Flexion +VE /-VE

Seated Forward Flexion +VE/-VE

ADDITIONAL TESTS