Untangled Living
Healthy Hub Wellness Centre
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PRIVATE AND CONFIDENTIAL PATIENT INFORMATION - POST PARTUM

PERSONAL DETAILS:

Name: ..... Date of Birth: ..... / ..... / ..... Age: .....

Address: .....

Town: ..... Postcode: .....

Do you have a Concession/Pension card? YES ☐ NO ☐

Do you have private health insurance cover for Myotherapy or Remedial Massage? YES ☐ NO ☐

If yes, please name your health fund: ..... Number: .....

Your GP's Name: ..... Contact: .....

WORK DETAILS:

Profession: .....

CONTACT DETAILS:

Phone (mobile): ..... Phone (home): .....

Email: ..... Phone (work): .....

HOW DID YOU HEAR ABOUT UNTANGLED LIVING?

☐ Yellow Pages Online
☐ Internet: www.untangledliving.com.au
☐ Social Media – Platform: .....
☐ Medical Referral – Please Name Doctor: .....
☐ Other Health Professional – Please Name: .....
☐ Referral from a Client of Our Business – Please Name: .....
☐ Other – Please List: .....

POSTPARTUM INFORMATION

Baby's Date of Birth: ...../...../..... Postnatal Care Provider: .....

Which hospital did you birth at? ..... Length of Gestation (weeks): .....

Previous Pregnancy: .....

Names/Age of Children: .....

Previous experience with massage during pregnancy: .....

Was your labour Induced or Augmented? YES ☐ NO ☐

Type of Birth (please circle):

Natural Natural Assisted VBAC Caesarian Emergency Caesarian Planned

Did you baby require any special care after birth? YES ☐ NO ☐

If yes, is your baby at home with you now? YES ☐ NO ☐

Are you breastfeeding? YES ☐ NO ☐

Which Maternal Health Care do you attend? .....

How are you sleeping? .....

EARLY POSTNATAL QUESTIONS ON YOUR RECOVERY (6 WEEKS)

Are you bleeding? YES ☐ NO ☐

Do you have any discharge from the suture site? YES ☐ NO ☐

Is your caesarian scar healing and the site is dry with no signs of redness? YES ☐ NO ☐

Do you have redness or heat on the breasts? YES ☐ NO ☐

Do you have calf pain? YES ☐ NO ☐

Did you have extended bed rest pre or post birth? YES ☐ NO ☐

Did you require any medical interventions during the birth? YES ☐ NO ☐

MEDICAL HISTORY

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING? Please ✓

- ☐ Heart/Blood Circulation Disorders
- ☐ Spinal Disorders
- ☐ Illness
- ☐ Injuries
- ☐ Accidents
- ☐ Osteoporosis/Arthritis
- ☐ Varicose Veins
- ☐ Allergies/Skin Problems
- ☐ Headaches
- ☐ Pain/Numbness
- ☐ Bladder Infection
- ☐ Uterine Bleeding
- ☐ Chronic Hypertension
- ☐ Blood clot or Thrombophlebitis
- ☐ Placenta Insufficiency
- ☐ Lower Back Pain
- ☐ Sciatica/Gluteal Pain
- ☐ Hip Pain
- ☐ Separation of Symphysis Pubis
- ☐ Separation of Abdominal Muscles
- ☐ Leg Cramps
- ☐ Carpal Tunnel
- ☐ Nausea
- ☐ High Blood Pressure
- ☐ Oedema/Swelling
- ☐ Diabetes
- ☐ Preterm Labour
- ☐ Abdominal Cramping
- ☐ Preeclampsia
- ☐ More than 2 consecutive miscarriages
- ☐ Other: (please specify)

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WHAT IS YOUR REASON FOR SEEKING TREATMENT TODAY?

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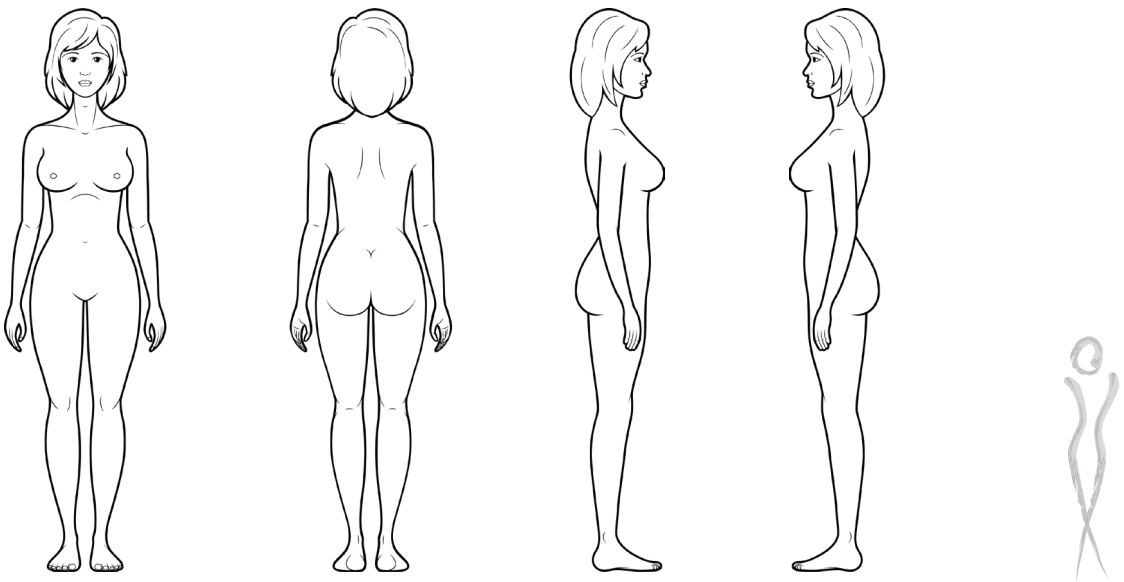
Please shade the areas you have pain or discomfort:



Please indicate your level of pain or discomfort on a scale 0 (none), 5 (moderate pain) and 10 (most pain) in the last week?

0 5 10

Have you sort previous treatment for this condition? YES ☐ NO ☐

Have you been referred? YES ☐ NO ☐ Name of Practitioner .....

Do you have scans, Xray or images for this condition? YES ☐ NO ☐

If yes, where were your scans taken? .....

How long have you had this condition? .....

When is this condition at its worst? Please ✓

☐ Constantly ☐ Morning ☐ Afternoon ☐ Evening ☐ Night/Sleeping ☐ Walking ☐ Sitting

What relieves your pain? .....

What aggravates your pain? .....

Are you on any medication? Please List: .....

Do you take any health supplements? Please List: .....

PLEASE READ CAREFULLY

I consent to Myotherapy/Remedial Massage treatment. I understand and agree that the modalities involved in the session may leave me with post-treatment tenderness, which should be short-lived.

I understand and agree to the best of my knowledge that I have provided the Practitioner with all the relevant information about my health and medical history. I intend this consent to apply to all my present and future Myotherapy/Remedial Massage care.

I the undersigned party, understand that I am financially obligated for any and all fees charged, with the understanding that the clinic is willing to prepare accounts, receipts, forms and reports as may be necessary to enable me to obtain reimbursement from health funds and insurers.

I give consent for the practitioners of Untangled Living to obtain radiology examinations and reports that may assist in the treatment of my condition. We may disclose your health information to other health care professionals, or require it from them if, in our judgment, that is necessary in the context of your treatment.

Your medical history and any records relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time.

Your health care is our priority, though if you are unable to attend your appointment, we would like to offer this time to other patients, as we regularly develop a cancellation list. If sufficient notification is not given, you will be charged for the full fee of the missed or cancelled appointment.

PATIENT NAME (or legal guardian for patients under 18 years):

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SIGNATURE:

..... Date: ..... / ..... / .....