



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):

Email:

DOB:

Occupation:

Health Fund:

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?)

Physio/Chiro/GP referral (Which One?)

Signage/Driving Past

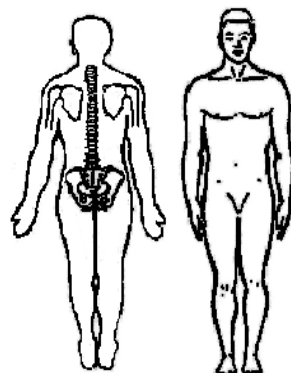
Website/Internet

Yellow/White Pages

Other Advertising

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.*

Your Health & Your Body

Circle if you receive treatment from:

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 | <i>How many weeks?</i> |
| 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?

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: specials/pricing/clinic changes

CANCELLATION POLICY

If you need to cancel: Outside 4 business hours there will be NO CHARGE to your account.
If you cancel: Within 4 business hours 50% of the fee will be charged to your account.
If you don 't show up: You will be billed for 100% of the fee.

- I have read and understood the cancellation policy

Signature: _____ Date: _____

If under the age of 18

Staff Use Only. Entered - YES NO

General Screening Form (Therapist Use Only)

General Posture Comments:

Feet:

Knees:

Gait:

Pelvis Ax:

General:

Standing Flexion:

ASIS/PSIS/Crest heights:

Leg Length:

Stalk Test:

Squish Test:

Int/Ext Hip Rotation:

SLR:

Bridge test:

Other Special Tests:

Other Comments:

Notes:

ROM:

Cx

Tx

Lx

Flex

Ext

RLF

LLF

R Rot

L Rot

