Bendigo Myotherapy

How did you hear about us?

Personal Details

Name________________________________ Date of Birth / / Gender ☐M ☐F
Address______________________________ Phone H______________________________
______________________________ W______________________________
______________________________ M______________________________
Email ______________________________ Occupation______________________________

Private Health Provider__________________ Membership Number___________________

Physician Name_________________________ Address______________________________
Phone________________________________ ______________________________

Medical History

Please tick if applicable

☐ Migraines
☐ Arthritis
☐ Spinal Conditions
☐ Recent Fractures
☐ Asthma
☐ Diabetes
☐ Epilepsy
☐ Cancer
☐ Heart Conditions
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Circulatory Conditions

☐ Skin Conditions - please list

☐ Allergies - please list

☐ Surgery- please list

☐ Pregnancy – please note your due date and list any complications.

☐ Other medical conditions or recent illness - please list

Please list all current medication

Please list any other practitioners you see for treatment

Please note other details you think may be important regarding your care or any significant family history or illness.

I declare the information given is true and correct and that it is my responsibility to inform Bendigo Myotherapy of any changes. I am aware Bendigo Myotherapy requires 24Hrs notice for changes to appointments made and failure to do so will incur a $50 cancellation fee*.

Signature **Date**

**Fee is subject to change at the discretion of Bendigo Myotherapy Pty Ltd.*