| | | DATE | |
|---|---|---|---|
| NAME | | | |
| DATE OF BIRTH | | GENDER | |
| ADDRESS | | | |
| EMAIL | | CONTACT NO. | |
| NEXT OF KIN/EMERGENCY CONTACT NAME AND NUMBER | | | |

# Japanese Integrated Medicine/ Anma Massage / CBD Massage

**COVID-19 QUESTIONS:**

| Question | Answer |
|---|---|
| **1. Have you come into close contact (within 6 feet) with someone who has a laboratory confirmed COVID – 19 diagnosis in the past 14 days?** | **YES/NO** |
| **2. Do you have any of the following: fever or chills, cough, shortness of breath or difficulty breathing, body aches, headache, new loss of taste or smell, sore throat?** | **YES/NO** |

If you suspect you may be experiencing any of the symptoms above, government guidelines advise you to isolate and consult with your GP. If you suffer from any medical conditions or allergies which could impact your ability to use our facility, please consult with your GP before doing so.

At Nimaya MindStation, we make all reasonable efforts to ensure a comfortable, clean and safe environment for you. To ensure this, please read the following and sign your name to indicate your understanding and agreement.

Reason for presentation (in brief) …………………………………………………………………….

………………………………………………………………………………………………………………….

Please circle:

Do you have pain? Yes\No Is the pain continuous or intermittent?

Previous treatment (Please give details of any previous treatment for your presenting condition)

………………………………………………………………………………………………………………….

………………………………………………………………………………………………………………….

………………………………………………………………………………………………………………….

Are you taking any medication (Drugs, herbs, homeopathic remedies; vitamins etc for this condition?) If so please indicate what you take, what dosage you have and how long you have been taking them?

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Your general health (to help us build a complete picture of you) Please circle:

Asthma yes\No Eczema yes\no

Allergic reaction yes\no

Angina yes\no

PMS\PMT yes\no

Regular insomnia yes\no

Diabetes Yes\no

Any known or Listed medical condition-please give details ……………………………….

……………………………………………………………………………………………………………………

**I confirm that I am a competent adult of at least 18 years of age and that by signing this form I am fully aware of the risks and hazards connected. I am voluntarily participating in therapy. I also hereby agree and understand that I shall have consulted with my own doctor prior if I am currently taking any medication or under a doctor's care for any reason or if I have or ought to have any reason for consulting my doctor. Thank you for providing this information to help us assess your individual case. The information that you have provided remains confidential. Please note: We require a minimum of 2 working days notice to change or cancel an appointment, late arrivals, missed appointments and late cancelation will be charged for.**

SIGNATURE........................................ DATE..............................