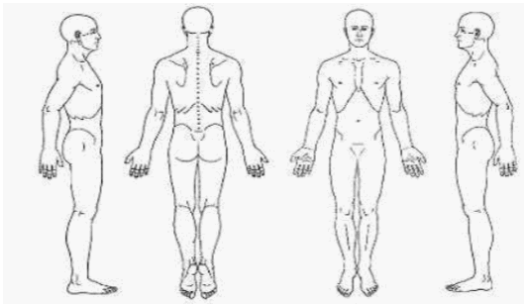
CONFIDENTIAL CLIENT HISTORY FORM

Name:	**DOB:**
Address:	
Occupation:	**Mobile Number:**
Email Address:	**Private Health Fund:**

Emergency Contact Name:	**Emergency Contact Phone Number:**
Emergency Contact Relationship:	

How did you hear about us?	☐ White Pages	☐ Gym
	☐ True Local	☐ Referral
	☐ Facebook	☐ Yellow Pages
	☐ Friend	☐ Office Massage
	☐ Website	☐ Event

Circle any specific areas you would like the massage therapist to concentrate on during the session



Please answer the questions below to the best of your knowledge

Have you had a professional massage before?	☐ Yes	☐ No
How long ago was your last massage?		
Are you pregnant? If so, how many weeks?		
Are allergic to any nuts or oils?	☐ Yes	☐ No
Do you have difficulty laying on your front for 30mins?	☐ Yes	☐ No
Do you have difficulty laying on your back for 30mins?	☐ Yes	☐ No
Do you sit for long hours at work?	☐ Yes	☐ No
Do you stand for long hours at work?	☐ Yes	☐ No
Do you perform any repetitive movement in your work?	☐ Yes	☐ No

Please turn to next page

CLIENT MEDICAL HISTORY

Please tick all conditions that apply **now**

☐ Abdominal or digestive problems	☐ Phlebitis	☐ Rash/Fungus/Athlete Foot/Tinea
☐ Allergies	☐ Pregnancy	☐ Sensitive Skin
☐ Anxiety	☐ Fibromyalgia	☐ Seizures
☐ Arthritis	☐ Headaches/Migraine	☐ Sinus Problems
☐ Asthma or lung conditions	☐ Hernias	☐ Skin Disorders
☐ Blood Clots	☐ Infectious Disease	☐ Sleep Difficulties
☐ Cancer/Tumors	☐ Lymph Node Removal	☐ Spinal disorders
☐ Chronic Pain	☐ Jaw Pain	☐ Sprain/Strain
☐ Chronic Fatigue	☐ Low/High Blood Pressure	☐ Stroke
☐ Circulatory/Heart Problems	☐ Motor Vehicle Accident/Trauma	☐ Tendonitis
☐ Constipation	☐ Numbness or Tingling	☐ Varicose Veins
☐ Depression	☐ Muscle or Joint Pain	☐ Vision problems or Contact Lenses
☐ Diabetes	☐ Muscle, bone injuries	
☐ Diarrhoea		
☐ Fatigue	☐ ***Other*** –	

Please list any drugs or medications being taken and the reason		
Name the Drug/Medication	Strength/Frequency	Reason

Please list any recent injuries or surgeries within the past 5 years

Please turn to next page

Massage Client Waiver and Disclosure Statement [**FOR CLIENTS UNDER 18 YEARS ONLY**]	
Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 18. I am the legal parent/guardian of the child and have read and understand this Waiver and Disclosure Statement and give consent for the child above to receive this treatment.	
Name of Parent/Guardian:	
Parent/Guardian Signature:	**Date:**

Consent for Treatment

I understand that massage is not a replacement for medical care and that no medical diagnosis will be made. As massage and bodywork therapy may be contraindicated due to certain medical conditions, I affirm that I have informed the therapist of all known medical conditions and will keep the therapist updated as to any changes in my medical condition going forward.

If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or manipulations, draping or environment may be adjusted to my level of comfort.

Draping using towels will be used during the massage session and only the area being worked on will be uncovered.

Any sexual conduct or behaviour towards the therapist during the massage session will automatically terminate the session immediately and client will be charged for the total session booked and not permitted to return to Adelaide Massage Health & Wellness.

I understand that:

- This is a massage treatment and is not a medical or allied health treatment (physiotherapy, osteopathy, chiropractic)
- I have viewed the therapists' qualifications
- The risks specific to my individual circumstances may have a bearing on my decision to proceed with the proposed treatment
- The therapist reviewed my health history before treatment commenced
- The therapist explained that the physical assessment I received may involve partial undressing and may require the therapist to palpate (touch) the area(s) of my body relevant to my presenting condition
- The therapist explained the treatment options to me the therapist explained the associated risk and possible side effects with the treatment options as described
- The therapist discussed the massage procedures, the areas of the body to be treated, the undressing and dressing procedures, the draping procedures and the positioning on the table for and during treatment
- The therapist established that the treatment session will be stopped should the treatment as first agreed to, require modification. The therapist will explain the reason for the change and any risks and/or side effects as a result of the change
- I can ask any questions in regard to any modification to the treatment plan. I should be totally comfortable with the explanation and reasoning for the change before consenting to the modification to the initial treatment plan
- The therapist has explained that I have the right to refuse treatment, to make changes to the treatment and to stop the massage at any time
- I have the right to request evidence for treatment that may include the abdomen, anterior and lateral chest, and buttock and / or groin areas. I understand I have the right to refuse treatment of these areas
- If I agree to treatment to any of the areas mentioned in the point above, I may be requested, by the therapist, to complete a consent form relevant to those areas

Only sign below if the above information is understood and has occurred

Client Name:	**Signature:**	**Date:**
Parent/Guardian Name:	**Signature:**	**Date:**
Therapist Name:	**Signature:**	**Date:**