Massage Adult Health History Form

Date:_____/_____/_____

Last name: _____First name:_____

Preferred name:_____

Address: _____

Contact number: _____ Occupation: _____

Email address: _____

Date of birth: _____Emergency name & contact number: _____

How did you hear about us? _____

Client History:

Please tick all conditions that apply (including past conditions – mark with P)

	Digestive problems		Fibromyalgia		Muscle, bone injuries
	Allergies		Headaches or migraines		Numbness or tingling
	Arthritis		Hearing problems		Pregnancy
	Asthma or lung conditions		Heart, circulatory problems		Rash, athletes foot/tinea
	Blood clots		Hernias		Seizures
	Cancer/Tumours		High/Low blood pressure		Skin disorders
	Chronic Fatigue		Infectious disease		Stroke
	Chronic Pain		Lymph node removal		Varicose veins
	Depression		MVA /trauma		Vision problems or contact lenses
	Diabetes		Muscle or joint pain		
	Fatigue		Other conditions not listed		_____

Details:

Current medications: including pain killers, vitamins, and other remedies:

Recent surgeries & dates:

Do you have any concerns regarding treatment? (e.g. do not massage face, ears or stomach):

Lifestyle Considerations: (Optional)

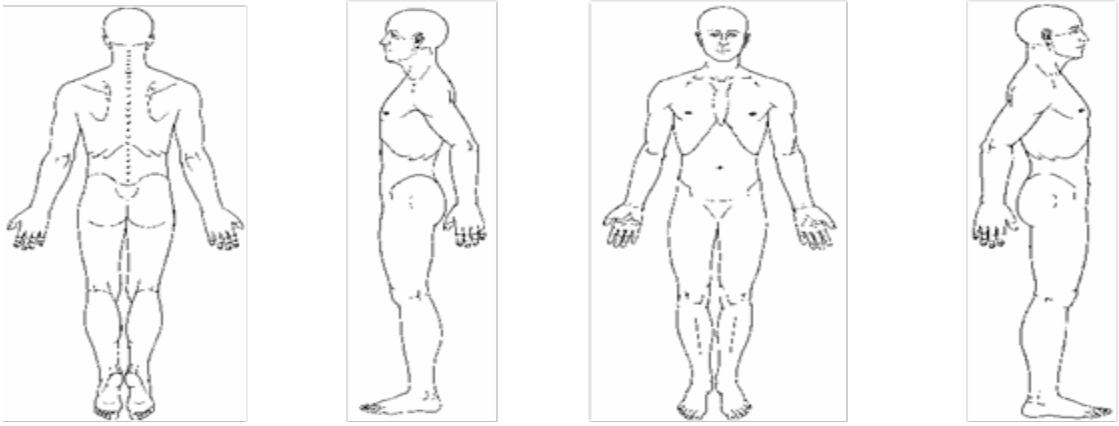
	Alcohol Per week		Leisure Activities/sport		Water Per day
	Eating Habits		Smoker		Work/Life balance
	Emotional wellbeing		Av sleep per night		Caffeine intake:

Treatment Goals:

Current symptoms requiring treatment:

History of complaint (how, when etc):

Use the diagram to indicate problem areas:



Behaviour and type of pain (constant/with movement/with activity/ sharp/shooting/dull aching):

Therapists Notes:

Informed Consent to Massage

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. There are certain medical conditions in which receiving massage may not be appropriate. In which case a referral from a physician may be required prior to services being provided.

Massage/bodywork is not a substitute for medical attention administered by a medical or allied health specialist ((physiotherapy, osteopathy, chiropractic). If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure/strokes may be adjusted. If I have any questions regarding my session, I will raise them. In addition, if I am uncomfortable for any reason, I may ask that the session be immediately stopped.

Draping will always be used during massage/bodywork sessions. No breast massage will be done without written consent of the client and therapist. Any illicit or sexually suggestive remarks made by me (the client) will result in the immediate termination of the session.

I understand that following a massage/bodywork session I may experience soreness in my body. Receiving cupping treatment can also result in cupping marks that may last up to a couple of weeks in some cases.

I understand and agree to not book in a massage treatment within 4 weeks of receiving a Covid 19 vaccination.

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

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

Name:_____Signature:_____ Date:_____