SEACREST
MASSAGE

Client Health History

At Seacrest we supply this form to new customers on arrival. If you wish to save time, you can print and complete the form in advance of your first appointment.

Full Name:_____ Date of Birth: _____ /____ / ____

Phone (Hm):_____ (Mob):_____

Address: _____ Postcode_____

Email: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Health Fund_____

Referred by: [ ] Internet [ ] Friend _____ [ ] Other _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes / No
If yes, please identify

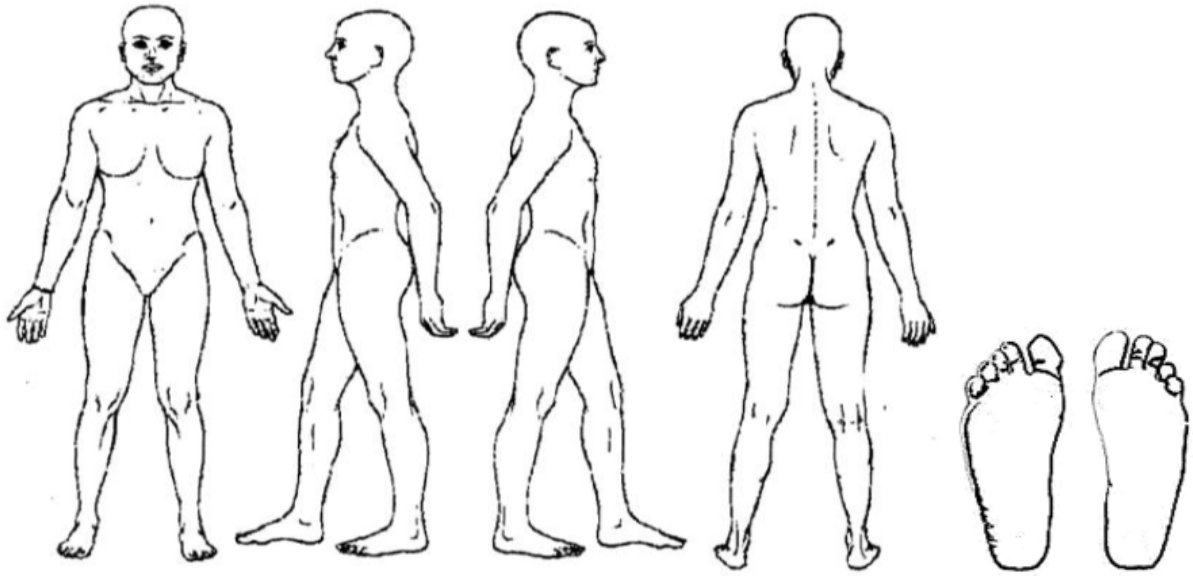
_____

How long have these symptoms been present for? _____

2. Do you have any particular goals in mind for this massage session? Yes / No
If yes, please explain

_____

Please circle any specific areas of discomfort:



Medical History

In order to plan a massage session that is safe and effective, we need some general information about your medical history.

3. Are you currently under medical supervision? Yes / No
If yes, please explain _____

4. Do you have any allergies? Yes / No
If yes, please explain
_____

5. Are you currently or have you taken any medication (including vitamins and supplements) in the last 3 months? Yes / No
If yes, please list _____

6. Do you do any form of regular exercise?
If yes, please list _____

7. Please list any previous serious illnesses you have had_____

_____

8. Do you have any significant family history of illness? Yes / No
If yes, please list _____

9. Do you have any trouble sleeping? _____

10. Please tick any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) epilepsy
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) anxiety / depression
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) osteoporosis
( ) easy bruising
( ) headaches/migraines

( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) Fibromyalgia
( ) heart condition
( ) high or low blood pressure
( ) pregnancy- If yes, how many months?

( ) cancer
( ) diabetes
( ) numbness or tingling
( ) back/neck problems
( ) varicose veins
( ) circulatory disorder
( ) atherosclerosis
( ) phlebitis

Please explain any condition that you have marked above

_____

_____

11. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?_____

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, (client's name) _____, consent to receive a massage treatment from Seacrest Massage. I have provided the massage therapist with a complete medical history and do not expect the therapist to have foreseen any medical conditions that I have not mentioned.

I understand that massage therapy may produce some temporary muscle soreness, mild bruising and light headedness. If I experience any discomfort or pain during my session I will tell the therapist so that the pressure or methods can be adjusted accordingly.

I understand that the massage therapist does not diagnose medical conditions, or perform spinal manipulations. Nor do they prescribe medical treatments and nothing said or done during the treatment should be construed as such.

I acknowledge that massage should not be performed under some circumstances and agree to keep the massage therapist updated with any changes to my health condition, and I release the massage therapist from any liability should I fail to do so.

I need at least 24hours notice if cancelling an appointment to avoid you being charged the full fee for your massage, as that time has been set aside for you. I understand that if I am late for my appointment my treatment time will be reduced accordingly.

Client's signature_____ Date _____