

Client Health History

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

Phone (Hm): _____ (Mob): _____

Address: _____ Postcode _____

Email: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Health Fund: _____ Senior/Student/Pension Card: _____

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

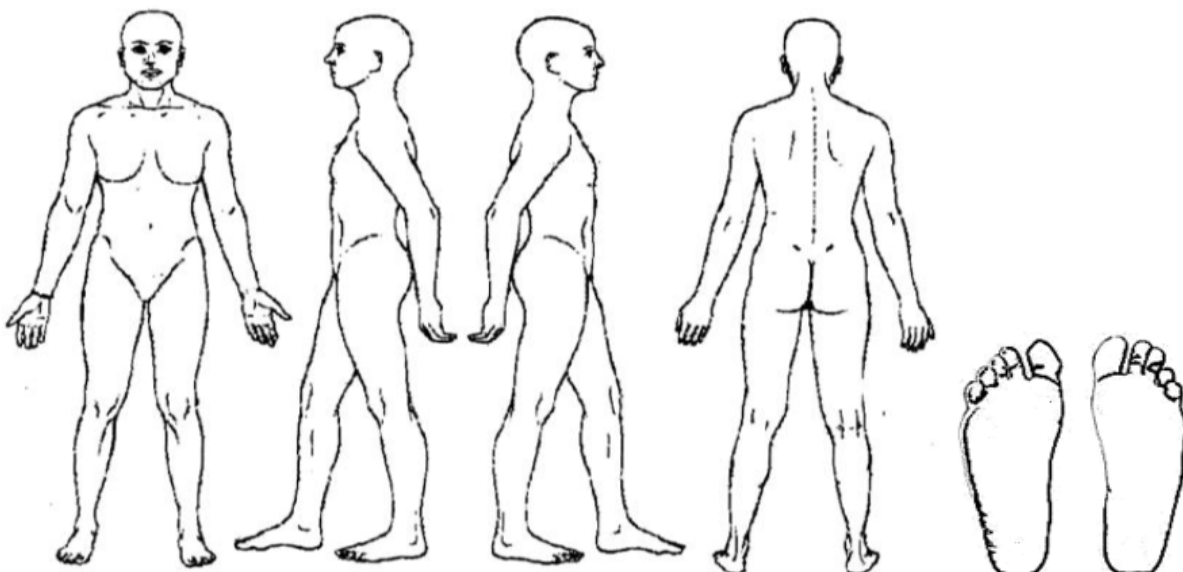
The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

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? Yes / No

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.

- | | |
|--|--|
| <input type="checkbox"/> contagious skin condition | <input type="checkbox"/> anxiety / depression |
| <input checked="" type="checkbox"/> open sores or wounds | <input type="checkbox"/> deep vein thrombosis/blood clots |
| <input type="checkbox"/> epilepsy | <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> recent accident or injury | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> recent fracture | <input type="checkbox"/> easy bruising |
| <input type="checkbox"/> recent surgery | <input type="checkbox"/> headaches/migraines |
| <input type="checkbox"/> artificial joint | <input type="checkbox"/> cancer |
| <input type="checkbox"/> sprains/strains | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> current fever | <input type="checkbox"/> numbness or tingling |
| <input type="checkbox"/> swollen glands | <input type="checkbox"/> back/neck problems |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> circulatory disorder |
| <input type="checkbox"/> high or low blood pressure | <input type="checkbox"/> atherosclerosis |
| <input type="checkbox"/> pregnancy- If yes, how many months? | <input type="checkbox"/> 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? _____

12. Do require treatment on and/or around your breast tissue?

13. Do you give consent for your therapist to work on and/or around your breast tissue?

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 understand that in booking an appointment I have booked the time of that therapist. On occasion that I am **late for an appointment** I understand that I am still accountable to pay for the booked amount of time.

In the event that an **appointment needs to be cancelled** I understand that the Seacrest Massage should be notified by the 5pm the day prior. Late cancellations will result in a fee (\$50 per hour) to allow payment for the time reserved for me by that therapist as there has not been efficient time for the therapist to replace my booking.

Client's signature _____ **Date** _____

Parent's/Guardian's signature _____ **Date** _____