remedial massage history

PERSONAL DETAILS

Date of first visit:

Name:

Address:

Post Code:

Phone (home):

Phone (work/mobile):

DOB:

Occupation:

Emergency contact details:

Primary Health Care Provider:

Chiropractor / Osteopath / Physiotherapist:

Referred by:

Health Fund:

Details of previous professional massage:

Exercise habits:

General diet:

Intake of:

Caffeine -

Alcohol -

Water -

Cigarettes -

Sleeping patterns:

General health:

INSURANCE DETAILS

Insurance Company:

Insurance Claim No:

Insurance Injury Manager:

Phone / Fax:

Work company contact:

Phone:

How many sessions recommended:

Cost of treatment per session: Sessions authorised:

MEDICAL HISTORY

Are you now under medical / therapeutic treatment? YES / NO

If so, for what condition

Musculoskeletal:

Bone or joint; sprains/strains; soft tissue	☐ YES	☐ NO	Osteoporosis	☐ YES	☐ NO
			Arthritis	☐ YES	☐ NO

Details/notes:

Nervous:

Headaches; sleep disorders	☐ YES	☐ NO	Numbness/tingling/weakness	☐ YES	☐ NO

Details/notes:

Cardiovascular:

Heart conditions	☐ YES	☐ NO	High / low blood pressure	☐ YES	☐ NO
Varicose veins; blood clots	☐ YES	☐ NO			

Details/notes:

Respiratory:

Breathing difficulties	☐ YES	☐ NO	Sinus problems; hay fever; asthma	☐ YES	☐ NO

Details/notes:

Reactions:

Allergies; skin disorders ☐ YES ☐ NO

Details/notes:

Digestive:

Constipation / bloating ☐ YES ☐ NO

Details/notes:

Other:

Pregnancy	☐ YES	☐ NO	Epilepsy	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	Lymphatic system	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO			

Details/notes:

Medication:

Pain	☐ YES	☐ NO	Psychiatric	☐ YES	☐ NO
Respiratory	☐ YES	☐ NO	Anti inflammatories	☐ YES	☐ NO
Blood thinners	☐ YES	☐ NO			

Details/notes:

Other comments:

PRESENTING CONDITION

Description:

Pain ☐ YES ☐ NO

Type:

Onset:

Duration:

Frequency:

Stiffness ☐ YES ☐ NO

Details:

What aggreviates it ☐ YES ☐ NO

Details:

What eases it ☐ YES ☐ NO

Details:

Previous treatment ☐ YES ☐ NO

Details:

Previous diagnostis procedures ☐ YES ☐ NO

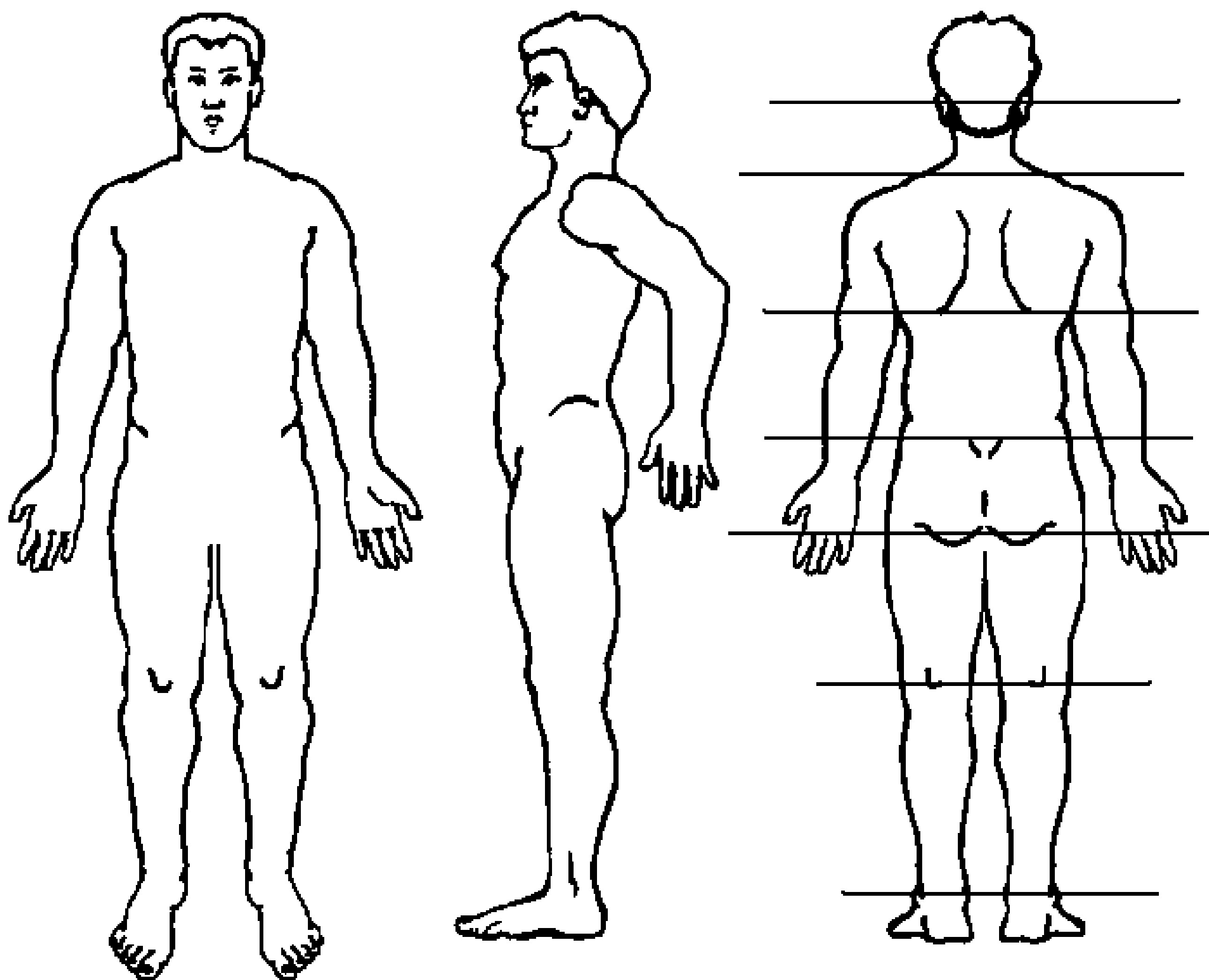
Details:

ROM tests:

Special tests:

Recommendations/referals:

Date:



Date: / /

Date: / /

Date: / /

massage therapy informed consent

I, (Client's Name)________________________________ have chosen to consult with and hereby give consent for massage therapy to be provided by (Therapist's name)________________________________ who I understand is a member of the Association of Massage Therapists Ltd (AMT).

I have provided a detailed medical history. I do not expect the therapist to have foreseen any previous or pre-existing condition that I have not mentioned.

I understand that massage may provide benefits for certain conditions but results are not guaranteed. These benefits may include relief of muscular tension, relaxation, reduction in the symptoms of stress-related conditions and provision of general wellbeing.

I also understand that massage therapy may produce side effects such as muscle soreness, mild bruising, increased awareness of areas of pain and light-headedness amongst other possible temporary outcomes.

I am aware that the therapist does not diagnose illnesses, prescribe medications nor physically manipulate the spine or its immediate articulations.

The therapist understands that I have the right to question procedures used and to receive an explanation of any procedures that the therapist performs.

I will tell the therapist about any discomfort I may experience during the therapy session and understand that the therapy will be adjusted accordingly.

Client Signature (or Guardian's): ________________________________

Therapist's Signature: ________________________________

Dated this ________________ day of ________________ 20____

Privacy Policy

This practice is committed to the privacy of its clients. Personal information is treated as confidential and is used only for the purpose for which it was collected.

Information kept on file will not be released to a third party without the express consent of the client or as required by law.