Client History Form

PERSONAL INFORMATION

Name _____

Date of birth _____ Email _____

Telephone: Mobile _____ Home _____

Address _____

Type of work you have done most of your life _____

Emergency contact **name** and **telephone** number _____

MEDICAL HISTORY

Please tick beside any items below that you identify with now, or in the past:

- ☐ Heart complaint
- ☐ Blood pressure problems If yes, mark: High / Low / Controlled
- ☐ Diabetes
- ☐ Presently pregnant
- ☐ Jaw or facial reconstruction or surgery
- ☐ Orthotics
- ☐ Implants e.g. breast, pacemaker, defibrillator, rods, pins
- ☐ Surgery including fractures, if yes specify _____
- ☐ Hernias
- ☐ Fits or convulsions
- ☐ Arthritis/Osteoarthritis/Osteoporosis/Rheumatism
- ☐ Migraine headaches
- ☐ Fibromyalgia
- ☐ Allergies If yes specify _____
- ☐ Anything else _____

_____

Current prescription and off-the-shelf medications _____

_____

Name of any other allied health professional you attend on a regular basis e.g. physiotherapist __

_____

What prompted you to book a massage today and what result are you hoping for? _____

_____

Gemfields Massage Therapies is a registered business name to Tracey Ross ABN 57 517 470 179.
3 Steele St, Rubyvale Q. 4702
M. 0437 921 970 E. gemfieldsmassage@yahoo.com W. gemfieldsmassage.net

MARKETING

How did you find out about Gemfields Massage Therapies? _____

Do you consent to receive marketing emails? ☐ Yes ☐ No

CONSENT TO TREATMENT

- *I, _____(please print your name) have chosen to consult with and hereby give consent for alternative therapy to be provided by Tracey Ross (the therapist) who I understand has a Diploma of Remedial Massage HLT52015, a Certificate of Pregnancy Massage and is an Emmett Technique Practitioner.*
- *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 treatment received 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 well-being.*
- *I also understand that treatment 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.*
- *The therapist has explained that I have the right to refuse treatment or changes to the treatment and that she or I have the right to stop the massage at any time.*
- *I undertake to advise the therapist of changes that may occur in any of my conditions at subsequent treatments that may occur.*

Signature:_____ Date: _____