

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 medications, including aspirin, ibuprofen, vitamins, homeopathic and natural remedies etc.

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? _____



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: _____