Tracey V Remedial Massage Therapy

CLIENT HISTORY & CONSENT FORM

Client Details:

Name: Chris Schubert DOB: 12/12/54 Occupation: Retired

Address: 4 Gordon Dve, KIALLA Vic 3631

Phone: (M) 0409532506 (H) _____ (W) _____

Email: cschoobz@gmail.com

Emergency Contact Name: Allison Schubert Relationship: Wife

Emergency Contact Number: 0417191917

Private Health Fund: _____ Card No: _____

Massage Information:

Have you had a Massage before? ☑ Yes ☐ No What type of massage? Relaxation

How did you hear about us? My wife

Would you like Aromatherapy Essential Oils used in the massage? ☑ Yes ☐ No

Are there any areas you do not want massaged (ie; Feet, Abdomen, etc)? ☐ Yes ☑ No _____

Medical History:

Please tick all conditions that currently apply & complete diagram on next page:

☐	Allergies	☐	Headaches / Migraines	☐	Nerve Damage / Injury
☐	Arthritis	☐	Heart Disease	☐	Pregnancy / Breastfeeding
☐	Asthma / Lung Conditions	☐	Hernias	☐	Rashes / Tinea / Skin Disorders
☐	Blood Clots	☐	High / Low Blood Pressure	☐	Seizures
☑	Cancer / Tumours	☐	Infectious Disease	☐	Stroke
☐	Depression	☐	Inflammatory Conditions	☐	Varicose Veins
☐	Diabetes	☐	Lymph Node Removal	☐	Whiplash
☑	Fatigue / Insomnia	☐	Motor Vehicle Accident / Trauma		
☐	Fibromyalgia	☐	Muscle or Bone Injuries / Fractures		

Other Conditions: Nueropathy BL Feet

Other Relevant Medical Information: Being treated for Multiple Myeloma by Peter Mac

Are you currently seeing any of the following Health Professionals for any reason?

☑ Medical GP ☐ Physiotherapist ☐ Osteopath ☐ Chiropractor ☐ Other Specialist Peter Mac

If so, for what condition(s): Multiple Myeloma

Are you currently taking any medications? ☑ Yes ☐ No

If so, please give details: Lots - See sheet from Doctor

Agreement and Consent:

By signing below, I *(please print name)* CHRIS SCHUBERT confirm that I have stated all my known medical conditions and answered all questions honestly and do not expect the therapist to have foreseen any previous or pre-existing conditions that I have not mentioned. Because massage should not be performed under certain medical conditions, I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part, should I fail to do so.

Signature of client: CP Schubert Date: 14/11/23

If under the age of 18, this must be signed by Parent/Guardian