



TARRENGOWER REMEDIAL MASSAGE CLIENT HISTORY FORM

Client Details:

Name: Cathrine Peace Date of Birth: 15/08/62 Identify as: M () F () A () O ()
 Contact phone number: 0472706102 Email address: cpeace62@gmail.com
 Occupation: Retired. Emergency Contact: Name: John Grand.
 Health Fund: HCF Relationship: Partner Phone: 0432 7111 20.
 Extras cover?
 Sports Activities: Cycling, golf, walking

Contraindications and Medical History:

1. Do you have any limitations for treatment?
2. [Female only] Is there a possibility you are pregnant?
3. What are your expectations for treatment?

Yes No
 Yes No

Improved joint stiffness + pain.

Varicose veins	Yes <input type="radio"/> No <input checked="" type="radio"/>	Skin diseases	Yes <input type="radio"/> No <input checked="" type="radio"/>
Sunburn	Yes <input type="radio"/> No <input checked="" type="radio"/>	Allergies	Yes <input type="radio"/> No <input checked="" type="radio"/>
Recent surgery/scar tissue	Yes <input type="radio"/> No <input checked="" type="radio"/>	Diabetes	Yes <input type="radio"/> No <input checked="" type="radio"/>
Major operations/accidents	Yes <input type="radio"/> No <input checked="" type="radio"/>	DVT/blood clots	Yes <input type="radio"/> No <input checked="" type="radio"/>
Inflamed/painful areas	Yes <input type="radio"/> No <input checked="" type="radio"/>	Fractures/dislocations	Yes <input type="radio"/> No <input checked="" type="radio"/>
High/low blood pressure	Yes <input type="radio"/> No <input checked="" type="radio"/>	Raised temperature	Yes <input type="radio"/> No <input checked="" type="radio"/>
Pacemaker	Yes <input type="radio"/> No <input checked="" type="radio"/>	Headaches/migraines	Yes <input type="radio"/> No <input checked="" type="radio"/>
Circulatory disorders	Yes <input type="radio"/> No <input checked="" type="radio"/>	Strains/sprains	Yes <input checked="" type="radio"/> No <input type="radio"/>
Supplements	Yes <input type="radio"/> No <input checked="" type="radio"/>	Cancer	Yes <input type="radio"/> No <input checked="" type="radio"/>
Neck/spine injury	Yes <input type="radio"/> No <input checked="" type="radio"/>	Infections conditions	Yes <input type="radio"/> No <input checked="" type="radio"/>
Arthritis	Yes <input type="radio"/> No <input checked="" type="radio"/>	Medications	Yes <input type="radio"/> No <input checked="" type="radio"/>

54ds

key crabs

*Bk inguinal
5/23*

*54ds
- sore/tender
@ knee*

zinc

Hyperflexion

Consent for Treatment

I understand that:

- This is a massage treatment and is not a medical or allied health treatment (physiotherapy, osteopathy, chiropractic)
- I have viewed the therapists' qualifications
- The risks specific to my individual circumstances may have a bearing on my decision to proceed with the proposed treatment
- The therapist reviewed my health history before treatment commenced
- The therapist explained that the physical assessment I received may involve partial undressing and may require the therapist to palpate (touch) the area(s) of my body relevant to my presenting condition
- The therapist explained the treatment options to me
- The therapist explained the associated risk and possible side effects with the treatment options as described
- The therapist discussed the massage procedures, the areas of the body to be treated, the undressing and dressing procedures, the draping procedures and the positioning on the table for and during treatment
- The therapist established that the treatment session will be stopped should the treatment as first agreed to, require modification. The therapist will explain the reason for the change and any risks and/or side effects as a result of the change
- I can ask any questions in regard to any modification to the treatment plan. I should be totally comfortable with the explanation and reasoning for the change before consenting to the modification to the initial treatment plan
- The therapist has explained that I have the right to refuse treatment, to make changes to the treatment and to stop the massage at any time
- I have the right to request evidence for treatment that may include the abdomen, anterior and lateral chest, and buttock and / or groin areas. I understand I have the right to refuse treatment of these areas
- If I agree to treatment to any of the areas mentioned in the point above, I may be requested, by the therapist, to complete a consent form relevant to those areas

Only sign below if the above information is understood and has occurred

Client
Name: Catherine Peerce Signature: Peerce Date: 29/11/22

Parent/Guardian
Name: _____ Signature: _____ Date: _____

Therapist
Name: Paul Gilders Signature: P. Gilders Date: 29/11/22