



## TARRENGOWER REMEDIAL MASSAGE

## CLIENT HISTORY FORM

### Client Details:

Name: Jan Hull

Date of Birth: 10/4/75 Identify as: M ( ) F ( )  ( )

Contact phone number: 0402 718 681

Email address: jjhull16@gmail.com

Occupation: Education Support

Emergency Contact: Name: Jason Hull

Health Fund: n/a

Relationship: Husband Phone: 0417563090

Extras cover? \_\_\_\_\_

Sports Activities: \_\_\_\_\_

### 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

LBP

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

*Perhaps ✓  
wrens*

*@wrens 1992*

**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: Jon Hull Signature:  Date: 14/8/23

**Parent/Guardian**  
Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Therapist**  
Name: Paul Gilders Signature: \_\_\_\_\_ Date: \_\_\_\_\_