



TARRENGOWER REMEDIAL MASSAGE

CLIENT HISTORY FORM

Client Details:

Name: LIZ GOOD
Contact phone number: 0425 806 339
Occupation: GARDENER
Health Fund: BUPA
Extras cover? YES
Sports Activities: Gardening

Date of Birth: 5/10/1952 Identify as: M () F () O ()
Email address: ljgood@gmail.com
Emergency Contact: Name: DAVE CLARKE
Relationship: HUSBAND Phone: 0425 792 931

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

Hopefully more comfort in movement

Varicose veins Yes No
Sunburn Yes No
Recent surgery/scar tissue Yes No
Major operations/accidents Yes No
Inflamed/painful areas Yes No
High/low blood pressure Yes No
Pacemaker Yes No
Circulatory disorders Yes No - obdies
Supplements Yes No VIT D
Neck/spine injury Yes No
Arthritis Yes No

LOST TO DETARITIS

Skin diseases Yes No
Allergies Yes No - Morphine, ampicillin
Diabetes Yes No
DVT/blood clots Yes No - 50 years ago
Fractures/dislocations Yes No - WAS @ 2022
Raised temperature Yes No
Headaches/migraines Yes No - occassion
Strains/sprains Yes No - shoulder/neck
Cancer Yes No
Infections conditions Yes No
Medications Yes No

HR
9 years
2012, 2014

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: LIZ GOULD Signature: E. J. Gould Date: 26/8/23

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

Therapist Name: Paul Gilders Signature: _____ Date: _____