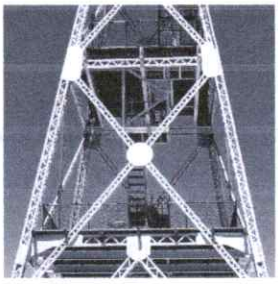

MASSAGE & MYOTHERAPY AUSTRALIA

TARRENGOWER REMEDIAL MASSAGE CLIENT HISTORY FORM

Client Details:

Name: MARGARET MCKNIGHT Date of Birth: 23/7/39 Identify as: M ( ) F (✓) O ( )

Contact phone number: _____ Email address: MMc36112@gmail.com

Occupation: RETIRED Emergency Contact: Name: Bill

Health Fund Medicare Relationship: HUSBAND Phone: _____

Extras cover? _____

Sports Activities: NIL

Contraindications and Medical History:

1. Do you have any limitations for treatment? PARKINSONS — (Yes) No
2. [Female only] Is there a possibility you are pregnant? Yes (No)
3. What are your expectations for treatment?

PAIN RELIEF - Pain & cramps @ night

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

Legs — L Knee — R Arm — Weight

PARKINSONS Medications

PANADOL OSTEO - 2/day.

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:_____ Signature: _____ Date:_____

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

Therapist
Name:___Paul Gilders_____ Signature:_____ Date:_____