Client History and Consent

Personal Information

Name: ANDREW DOUGLAS Gender: (M/F/X) M Date of Birth: 9/9/1947

Address: P.O BOX 282 QUEANBEYAN

Phone: 0411 872 515 Email

Occupation: MELINDA. MCCALLUM

Emergency Contact: ~~04 Ag~~ Relationship: WIFE Phone: 0429 122 700

How did you hear about me?

Medical Information

Are you taking any medications? ☐ Yes ☐ No

If yes, please provide details:

Do you have any allergies / sensitivities? ☑ Yes ☐ No

If yes, please provide details: EGG

Are you pregnant? ☐ Yes ☑ No

If yes, please provide details?

Any high risk factors?

Do you suffer from chronic pain? ☑ Yes ☐ No

If yes, please explain:

What makes it better?

What makes it worse?

Please indicate any of the following that apply to you:

☐ Headaches/Migraine	☐ Varicose Veins
☐ Numbness/Tingling	☐ Skin Condition
☐ Fibromyalgia	☐ Diabetes
☐ Osteoarthritis	☐ High/Low Blood Pressure
☑ Osteoporosis	☐ Heart Condition
☐ Fracture	☐ Stroke
☑ Joint Replacement(s)	☐ Kidney Dysfunction
☐ Sprains/Bruising/Swelling	☐ Blood Clots
☐ Inflammation	☐ Cancer
☑ Spinal Problems ☐ Whiplash	☐ Infectious Disease ☐ Other

Please provide details for any conditions selected above:

Massage Information

Have you had a professional massage before? ☑ Yes ☐ No

What is the main reason for your visit? PAIN

What type of massage are you seeking?

☐ Relaxation ☑ Therapeutic/Deep Tissue

☐ Other:

What pressure do you prefer?

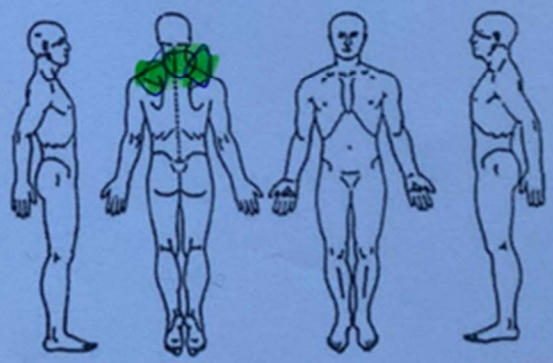
☐ Light ☐ Medium ☐ Deep ☑ Unsure

Are there any areas (feet, face, abdomen, etc.) you **do not** want massaged? ☐ Yes ☐ No

Please provide details:

What are your goals for this treatment session?

Please circle any areas of discomfort:



Please turn over

Your Consent

By signing this form, I confirm that I understand:

- *Massage therapy involves touch directly on the skin, oil(s) may be used.*
- *All documentation completed in relation to my treatment will remain confidential to my Therapist.*
- *My Therapist is not qualified to give a medical diagnosis and does not offer any cure or alternative to medical treatment.*
- *I may withdraw my consent at any time by written notice to the Therapist.*

I have completed this form to the best of my knowledge and stated all my known medical and physical conditions. I understand that whilst massage is generally beneficial, there are some medical conditions which may be contraindicated for massage. I, therefore, acknowledge it is my responsibility to inform my Therapist, prior to the commencement of any future treatment, of any changes to my medical or physical health status.

I consent to the initial and ongoing consultations with the Therapist. I agree that this consent form will remain active for future visits to the Therapist unless I otherwise notify the Therapist in writing.

Client Signature: M Douglas Date: 24/1/23