Remedial Massage Therapy Confidential Client History Form

Personal Information:

Full Name: John Trotter DOB: 22/12/68 Age: 56 ☑M ☐F

Phone: 0498268905 Email: _____

Occupation: DSP Referred By: SELF

Address: 21 TWARTZ RD ROSEWORTHY

Private health: _____ Member number: _____ Patient number: _____

Emergency Contact: KRYSTINA TROTTER Phone: 0435927533

Medical Information:

- Do you have any fever/flu like symptoms/ have you been in contact with someone who is COVID positive? NO

Please tick the relevant box if you currently have, or you previously had any of the following.

- ✓ Inflammation
- ○ Skin conditions/ broken skin
- ○ Whiplash
- ✓ Surgery/Operations
- ○ Infectious diseases
- ○ Sprain/Bruises or Bruise Easily
- ✓ Injuries/Accidents
- ○ Abnormal swelling
- ○ Varicose Veins
- ○ Heart conditions
- ○ High/ Low blood pressure
- ✓ Arthritis
- ✓ Any Current/ Ongoing undiagnosed or severe pain concerns
- ✓ Fractures
- ✓ Spinal Problems
- ○ Diabetes
- ○ Epilepsy
- ○ Any form of Cancers
- ○ Other.....
- ○ Any Allergies_____

Are you pregnant Yes / (No) / Could Be?

Are you taking any medications? (YES) NO If yes, please provide details? _____

CANNABIS OIL, PANEDINE FORTE

Are you seeing/having treatments from other professionals? If yes, please provide details.

RIVERVIEW CHIROPRACTIC, TACTILE THERAPY

Please Provide Any Other Details:

PARALYSIS ON LEFT SIDE (MVA)

Physical/Recreational Activities: GOLD PROSPECTING, FOSSICKING

General State of Health and Well-Being: HEALTHY

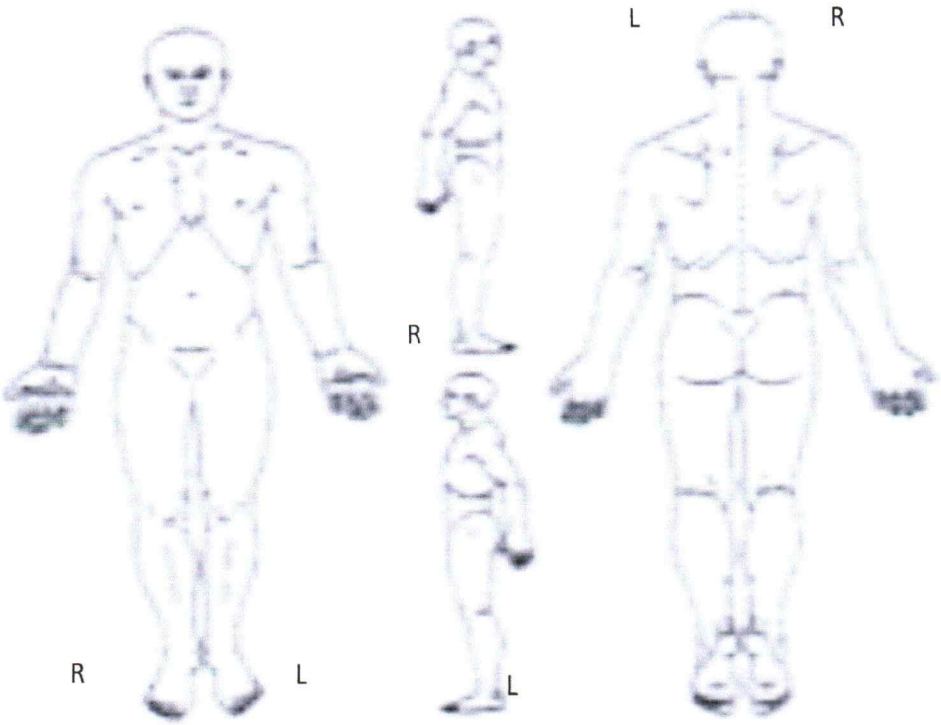
Have you had a massage before? If yes, when was your last massage? and did it meet your expectations? 2 MTHS

Please circle which you prefer during your massage.: No talking / Some / Don't mind

What type of music do you like to listen to during your massage? ANY

Please circle your main concern for your visit Relaxation Tension Tightness

Areas specifically you want to focus on today. NECK, SHOULDERS, BACK, SCIATICA Or mark on the diagram



Please Note:

Massage generally is beneficial; however, it may not be appropriate or may need to be modified to best suit your needs and state of health.

24 hours' notice is required if you wish to cancel or reschedule your massage appointments. By signing this form, you acknowledge and understand a fee may apply if you do not provide 24 hours' notice.

By signing this form, you are declaring the information provided is complete and correct to the best of your knowledge.

Client Signature: _____ **Date:** 2/7

Therapist Signature: _____ **Date:** 2/7/25

Client consents to treatment plan? ✓