Kylie Miller

DOB 21 Oct 1984
Occupation Massage Therapist

Appointments

Date	Time	Type	Practitioner
6 Jun 2024	1:00PM – 2:00PM	Gift Certificate - Book your Massage	Christine Jervis
22 Mar 2023	9:30AM – 10:30AM	Gift Certificate - Book your Massage	Christine Jervis

Treatment Notes

Standard Consultation - Remedial Massage

Practitioner: Christine Jervis
Appointment: 6 Jun 2024, 1:00PM
Created: 6 Jun 2024, 2:40PM
Last updated: 6 Jun 2024, 7:50PM

Standard Consultation - Remedial Massage

Presenting complaint (relevant medical history or client info)	What's going on now - feeling sore with whole body especially shoulders, back and r long peroneal twitchy with running Feedback from previous treatment - been a long time since last massage, Bowen last week
Medication or relevant procedures / info identified that may affect the massage.	
Details of Medications / Red Flags / Precautions needed etc (i.e. conditions listed above)-	
Assessment / Testing done (including ROM) / Observations	Verbal consent obtained. ROM - not checked today Anything noteworthy - no, athletic build, R long peroneal pain, anxiety and heart palpitations Anything specific to massage (E.g. no foot massage) - no
Treatment details - what was done today to help the client	Pressure used - 3 Music - Yanni if there Aromatherapy Massage oil - Lavender Spritzer - joyful Remedial techniques - shoulders, legs and back
Hot Pack	Lower Body

Hot Stones	2 x Hips; 2 x Back/Shoulders; Cold stones on face
Hot Wet Towels	Feet; Face
Topical Treatment	Fisiocrem shoulders/neck
What parts of the body were massaged?	Full Body Treatment; Stomach; Gluteals / Lower Back; Neck / Shoulders; Arms - Supine; Legs - Prone; Legs - Supine; Feet; Head / scalp; Face / sinuses
Where any specific trigger points used?	Rhomboids; Upper Traps; Lev Scaps; Pecs; ITBs; TFLs; Psoas
Body Chart	
Feedback after treatment -	Felt good after massage
Plan for future results / treatment / progress / homework (including discussion with client, advice, stretches)	Julie Hamlyn - see about foot pain, Mind Matters for mind and anxiety. Add a sauna next time.

Infra-Red Sauna (if applicable - info is below)

Time in Sauna (minutes) -	
Feedback after treatment -	

Patient Forms

There are no patient forms for Kylie Miller.

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Massage Client Record

Personal Information – your honest info helps plan the best treatment for you.

Full Name KYLIE MILLER		**Date of Birth** 21-10-84
Postal Address 4 BLOOMFIELD CLOSE, MT SHERIDAN		
Home Phone –	**Work Phone** –	**Mobile** 0405116497
Email Address kylie.miller84@yahoo.com		
Emergency Contact Details – Name and Number Mark Debono - 0422675005		
Occupation – how long? MASSAGE - 15YRS	**Current Doctor** MT SHERIDAN MEDICAL	**Health Fund** NONE
How did you find out about us? Who referred you? CHRISTINE JERVIS		**May I thank them for referring you?** (Yes) No

Please circle: what is the fastest / best way to get a response from you? (E.g. when confirming a massage)
(Text Message) Home Telephone Work Telephone Email Facebook Message

Physical activities / hobbies / exercise. Do you sit or stand for long hours? (E.g. computer/driving)
MASSAGING LONG HOURS, RUNNING AFTER KIDS

Medications – prescribed or natural:
MAGNESIUM

Medical History (Operations / Illnesses / Accidents / Injuries)
NONE

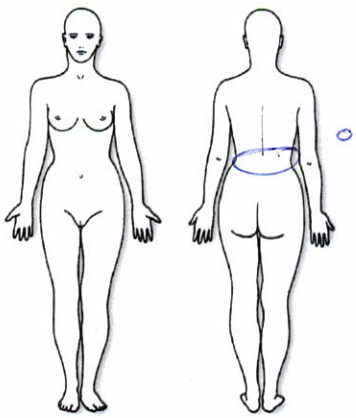
Please circle any areas you DON'T want massaged Face Head Chest Stomach Back Buttocks Arms Legs Feet

Please circle what type of massage pressure you prefer: Gentle Firm (Hard) Very Hard

Some conditions affect massage. Please tick and circle things below that apply to you NOW.

- □ Allergies / Asthma / Sinus / Skin sensitivity
- □ Any contagious disease / Cold / Flu
- □ Anxiety / Depression
- □ Arthritis / Bone or Spinal problems / Osteoporosis
- □ Bruise Easily / Blood clotting problems / Swelling
- □ Cancer / Recent Illness / Surgery
- □ Diabetes □ TYPE 1 □ TYPE 2 □ GESTATIONAL
- □ Dizziness / Numbness / Tingling / Cold hands / Cold feet
- □ Fractured bones / Cuts / Burns
- □ Headache □ MILD □ SEVERE □ PERSISTENT
- □ Hearing or Vision problems / Hearing Aid / Contact lenses
- □ Heart Problems / Blood Pressure □ HIGH □ LOW
- □ Pain □ SHARP □ DULL □ ACHING
  When is your pain worst? □ MORNING □ NIGHT □ ALL THE TIME
  What relieves it? □ ICE □ HEAT □ REST □ MOVEMENT
  □ MEDICATION □ TOPICAL CREAM □ other -

Please circle any areas of soreness or pain on the body chart:



Any extra health details:

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Massage Client Record

Menstrual and Fertility Conditions – please tick (or enter) what applies to you	
☐ Painful Periods	☐ PCO (Polycystic ovaries)
☐ Irregular Periods	☐ PCOS (Polycystic Ovarian Syndrome)
☐ Excessive Bleeding (>1pad/tampon per/hr)	☐ POF (Premature Ovarian Failure)
☐ Fibroids	☐ Endometriosis
☐ Painful Ovulation	☐ Failure to Ovulate
☐ Miscarriage (once)	☐ Low AMH
☐ Recurrent miscarriage	☐ Retroverted or inverted uterus
☐ Other -	

Symptoms experienced prior to and during menstruation	
☐ Lower back ache	☐ Change in bowels ☐ Constipation ☐ Diarrhoea
☐ Headaches	☐ Pain / numbness in legs ☐ left leg ☐ right leg
☐ Dizziness	☐ Cramps ☐ left side ☐ right side ☐ lower abdomen
☐ Dragging sensation	☐ Dark thick blood at beginning of menstruation
☐ Heaviness or pressure in lower pelvis	☐ Dark thick blood at the end of menstruation
☐ Increased urination	☐ Blood clots
☐ Anything else you notice -	

Pregnancy and birth history	
Are you currently trying to get pregnant? If yes, how long have you been actively trying?	
Are you under treatment for infertility? i.e. IVF	
How many pregnancies have you had? 4 Number of deliveries? 3 How long were your birth hours for each delivery? APROX 5HRS	
How would you describe your experiences or feelings about your: • Pregnancy - GREAT • Labour/delivery - NO PROBLEMS, CALM. • Post-partum recovery - BOUNCED BACK QUICKLY	
Did you have any interventions / complications?	
Please tick what applies to your experiences:	
☑ Natural Birth	☐ C-section
☐ Water Birth	☐ Termination
☐ Epidural / Pethidine	☐ Miscarriage
☐ Forceps / Ventouse	☐ Ectopic

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Massage Client Record

Reasons for your visit

Do you have any particular goals for your massage treatments?

GENERAL TENSION.

What is your primary concern? Does it interfere with your sleep, work, relationships or everyday life?

Important personal questions...

Do have any digestive complaints? E.g. Constipation (going <1 per day), diarrhoea, hard or loose bowel movements, abdominal pain, bloating or discomfort.

NO

How well is your bladder working? Any infections or bladder weakness, difficulty experiencing orgasms, trouble when you sneeze or do you need to urinate frequently?

OK

Any falls / injuries to your sacrum, tailbone or head?

TAILBONE MANY YEARS AGO

Have you had any surgery on your abdomen / lower back?

NO

Trauma is stored at a cellular level in the body and some massage techniques can affect your body's response (and your emotional state) so it's important for a therapist to understand your body's history. Have you witnessed or experienced any emotional abuse, physical abuse or trauma in your life?

NO

Do you fall asleep easily and how well are you sleeping through the night?

WAKE UP TIRED. KIDS INTERRUPT SLEEP

Have you told your doctor or health practitioner about starting massage treatment? Yes (No)

Please read, confirm and sign

- [x] I understand massage treatment is not a replacement for medical care.
- [x] Massage therapists do not diagnose illness/disease or perform thrust manipulations.
- [x] I will keep my massage therapist updated on any changes to this information and my health.

Client Signature [signature] **Date** 13/4/18

Therapist Signature [signature] **Date** 13/4/18

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Massage Informed Consent

PLEASE READ THIS INFORMATION CAREFULLY

Every massage treatment has potential risks...

Such as causing pain, muscular discomfort, fatigue, bruising, infection, burns (from heat therapy), feeling sleepy, fainting, aggravating existing conditions, creating an aromatic response (irritating/photo-sensitising skin), causing blood pressure changes or interacting with medications.

To minimise possible risk, you must:

Be honest

About all the information you provide regarding your health: especially for heart, kidney, immune or health problems or if you are pregnant/breastfeeding or trying to get pregnant. Massage should not be performed under certain medical conditions.

Tell your therapist

If you have sensitive skin, bruise easily, have any known health problems, if the temperature becomes unbearable (too hot or cold), if the massage pressure level is too intense or if you become uncomfortable or feel unwell at any stage during a treatment.

After treatment

It is common to feel relaxed or sleepy – please get up very slowly from the treatment table and give yourself time to adjust before driving/using stairs. Keep well hydrated with water especially in the 24-48 hours after treatment. Delay your shower for 2 hours to help essential oils keep working.

Please read, confirm and sign

- ☑ I understand there are possible significant risks, complications and side-effects to any treatment I receive.
- ☑ I know that the therapist and I both have the right to refuse or stop any treatment at any time.
- ☑ I have the right to ask for further information or to refuse treatment of breast, buttock or groin areas.
- ☑ I agree to read the information brochure I will be given to take home at the end of my first treatment.

It may be necessary to discuss your condition and/or treatment with your doctor, physiotherapist or referring health care practitioner - you will be informed if this occurs.

Do you agree to such discussion to improve your health? ☑ Yes ☐ No

Client Signature KMiller

Client Name KYLIE MILLER **Date** 13/4/18

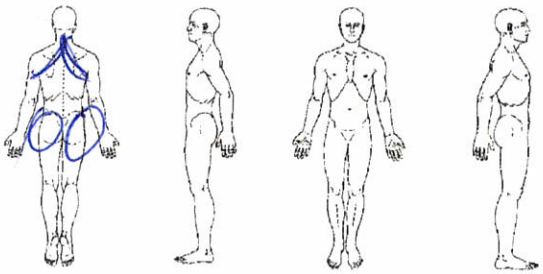
TREATMENT NO. 1

DATE: 13/4/18
TIME: 1
PAID: $44
REC.No:
AIR TEMP: 23
MUSIC: All tunes
FACE CREST:
SUPINE SCENT: lemon.
OIL BLEND: M/F
HT x2
CST
HST x4

EXTRA
NEXT APPT:

S = neck & shoulders.

Kylie



O/A: ↑ generally.
Scaps T.

✓ Full Body ☐ STOMACH
ARMS ☐ Prone ☐ Supine LEGS ✓
TP
Fx mid traps
☑ Talked ½ ☐ Quiet Breathing
ROM
FBACK

P = D-T