Confidential Client Consent Form Date:

PERSONAL DETAILS

Name: (Mr, Mrs, Miss, Ms) .....

D.O.B: 31·12·1955

Phone: Work: — Mobile: 0427006794 Home: —

Email: lindyefarrer@icloud.com

Occupation: Retired Registered Nurse

Hobbies: gardening

Pension Type: — Funded by: —

Health Fund: Bupa Do you require a receipt for health insurance claims? Yes ☑ No ☐

Parent or Guardian Consent: If person is under 18 years of age

Name: ..... Relationship: ..... Signed: .....

EMERGENCY CONTACT

Contact name and phone no (in case of emergencies): .....

BRIEF HEALTH HISTORY

Height: 163cm Weight: 92kg

Referred by: Self Friend GP Other Facebook.

Reason for Attendance: Relaxation Remedial Gift Voucher Specific Injury Diagnosed Condition

Circle Previous Treatments:

Chiropractic	Acupuncture	Lymphatic Drainage	Naturopathy	Nutrition	Massage	
Allopathic Medicine	Homeopathy	Occupational Therapy	Podiatry	Reiki	Bowen Therapy	
Oncology Massage	Reflexology	Thai Massage	Shiatsu	Physiotherapy	Exercise	Other

Current Stress Levels: Low 1 2 3 4 5 High Do you regularly? Yes ☐ No ☑

Type of exercise currently participating in:

Exercise: minimal Frequency: .....

Exercise: ..... Frequency: .....

Exercise: ..... Frequency: .....

BRIEF MEDICAL HISTORY (Please give details accordingly as it may be necessary to contact your GP or specialist). **Tick** all conditions that apply to your current health status. Put a **P** for past conditions.

Pain / Stiffness		Renal System		**Nervous System**	
Neck / Jaw	✓	UTIs	P	Multiple Sclerosis	
Back	✓	Incontinence		Confusion	
Shoulder / Arm / Hand		Cystitis		Memory Loss	
Leg	✓	Kidney / Gall Stones		Altered Alertness	
Is the Pain/stiffness at Night	✓	Seizures		Body Fatigue	✓
Is the pain/stiffness in Morning	✓	**Endocrine System**		General Muscle Weakness	✓
Pins & Needles / Tingling	✓	Thyroid Problems Hypeo	✓	Depression / Anxiety	
Arms / Hands / Fingers		Adrenal Problems		Numbness	✓
Legs / Feet / Toes	✓	Pancreas – Hypergiycaemia		**Musculoskeletal System**	
Arms / Hands / Fingers		Pancreas – Hypoglycaemia		Arthritis	
Cold Extremities		**Respiratory System**		Muscle or Joint Pain	✓
Hands		Asthma		Muscle or Bone Injuries	
Legs / Feet minor	✓	Sinusitis		Numbness or Tingling	✓
Swelling of Extremities		Rhinitis		Hernias	
Arms / Hands/ Legs/ Feet		Bronchitis		Joint Reconstruction	
Balance		Cough		Cramping Nocte	✓
Weakness legs - feet	✓	Sore Throat		Scoliosis / Lordosis / Kyphosis	
Clumsiness		Hay Fever		**Women Only**	
Loss of Balance minor	✓	Lung Conditions		Difficult Menstruation	
Vertigo		**Cardiovascular System**		Breastfeeding	
Integumentary System		Chest Pain		Menopause	
Eczema		Heart Problems / Angina		Pregnancy	
Psoriasis		Palpitations		Premenstrual Syndrome	
Dermatitis		Pacemaker		Fibroids	
Blood Clots or DVT		High / Low Blood Pressure	✓	**Men Only**	
Cysts		Varicose Veins		Prostate Problems	
Growths		Stroke (CVA) – TIA		Testicular Pain	
Warts		Swelling of the ankles or feet		**Other**	
Moles		Fluid Retention		Depression	
Rash, Athletes Foot/tinea		Anaemia		Cancer/Tumours Breast 2001	P
Gastrointestinal System		Haemorrhoids		Vision Problems / Contacts	
Abdominal or Digestive Problems		Cold Hands and Feet	✓	Hearing Problems	
Diarrhoea / Constipation		**Immune System**		Infectious Disease	
Nausea / Anorexia		Frequent Colds / Flu		Motor Vehicle Accident/Trauma	
Gastric Ulcers		Recurring Infections		Diabetes	
Indigestion		Chronic Fatigue always tired		Hepatitis B / C	
Reflux		Fibromyalgia		HIV / AIDS	
IBD / Crohn's or UC		Allergies		ADHD / Autism / Asperger's	
Glandular Fever		Other M.G.U.S.		Headaches/ Migraines	

General Wellbeing

(Fatigue) Tension (Fog) Stress / Irritability / Nervousness / Mood Swings / Sleep Problems / Fevers / Sweats / Loss of Smell / Loss of Taste ✓ slight

Do you have any other conditions not listed? .....

PRE-ASSESSMENT QUESETIONS

Are you a smoker? Yes ☐ No ☑

If yes, number of cigarettes per day: .....

Do you have any known allergies? (please list) No

If you have allergies, what happens upon contact or ingestion: .....

.....

Have you had any previous fractures and / or surgeries? Yes ☐ No ☑

If yes, please list the body parts that were injured and / or affected: .....

.....

.....

Please list current medications being taken, including vitamins and supplements

Medication / Vitamin / Supplement	Dosage (mcg/mg) per Day	Duration of Medication	Related Condition
Telmisartan	HCTZ 80/25	10 yrs	Hypertension
Amlodopine	2.5mg	2 yrs	Hypertension
Thyroxine	100 mcgs	10 yrs	Hypothyroid
Gabapentin	300 mgs	B.D	neuropathy
Palexia	50mgs	Daily	neuropathy
Vitamin B.			
Vitamin D	50,000 u/s	weekly. 5 yrs.	
Magnesium x2		5 yrs.	cramps/rest.

Please list any surgeries

Surgery	Date

INFORMED CONSENT

There is always a risk associated with any form of bodywork treatment. To reduce the chance of risk occurring it is important to answer all questions about your health, fully and honestly. Your therapist will explain the treatment to you before they commence. If however, you have any questions or if you require further explanation, you should ask your therapist. Please read the information below carefully.

Possible Risk	Treatment Modality	Strategies to minimize risk
Pain	Deep Tissue Massage	Tell you therapist if you become uncomfortable or experience any pain during you treatment
Bruising	Deep Tissue Massage	Tell your therapist if you bruise easily or if you have any underlying bleeding condition
Relaxed / Sleepy	Massage Therapies / MLD	It is common to feel relaxed and sleepy after a treatment, so avoid getting up quickly from the treatment table. Give yourself some time to adjust before driving. Keep hydrated and drink plenty of water.
Fainting	Massage Therapies	Do not skip a meal before a treatment
Aggravation of your condition	Remedial Therapies	It is possible that your condition could become aggravated for up to 24 hours after treatment.

Please tick the boxes once read and understood

✓	I have read and understood the information outlined in the table above
✓	I verify that the client information and history given is, to the best of my knowledge, true and accurate
✓	I will advise the therapist of changes that may occur in any of my conditions at any future treatments
✓	I will advise the therapist of any changes to my medications, including supplements, herbal, homeopathic and naturopathic remedies at any future treatments

It may be necessary to discuss your condition and/or treatment with your Doctor, Physiotherapist or referring practitioner for the purpose of improving your well-being.

Do you agree to allow these discussions to take place? Yes ☑ No ☐

Consent is required to massage each area of the body. Please indicate with a tick the areas you would like included in your massage today and in future treatments.

☑ Back ☑ Buttocks ☑ Legs ☑ Feet ☑ Arms ☑ Stomach ☑ Chest ☑ Face ☐ Head

I do/~~do not~~ have my Specialist/GP's consent. I have read and agree with all the details on this form, and have no other medical conditions other than that stated. I understand that by not sating all my health details I will be accepting the bodywork treatment at my own risk. Personal information provided on this form will be treated as confidential. Exception is only allowed where legally required or where failure to disclose information would breach duty of care.

Signature of Consent: ..... Date: 19/8/2025

LYMPHOEDEMA / LIPOEDEMA HISTORY

Type of Oedema:

	Primary Lymphoedema ?		Secondary Lymphoedema		Vascular Oedema
✓	Lipoedema ?		Protein Deficiency Oedema		Phleboedema

Diagnosis Date: .....

Do you know the cause of the oedema? ? congestion

Have you been treated for cancer? Yes ☑ No ☐

Type of Cancer: Breast

Staging: (1) 2 3 4

Have you had any lymph nodes removed: Yes ☑ No ☐ (14) Date of surgery: 2002

Nodes Removed: Type: Axillary - right Number: 14

Have you had Chemotherapy? Yes ☐ No ☑ Date of treatment: .....

Have you had Radiotherapy? Yes ☑ No ☐ Date of treatment: 2002

Have you had Laser treatment? Yes ☐ No ☑ Date of treatment: .....

Laser Clinic: —

Have you received any other treatment for your Oedema? Yes ☐ No ☑

Date of Treatment	Type of Treatment
	Medication
	Combined Decongestive Therapy
	Compression Garments
	Pneumatic Pump
	Surgery (Liposuction)
	Other

Have you ever had an infection at the site of the Oedema? Yes ☐ No ☑ Date of treatment: .....

Have you recently noticed any changes in the: Skin Yes ☐ No ☑

Nails Yes ☐ No ☑

Are there areas of the limb harder than usual? Yes ☐ No ☑

At home do you have someone to help you with daily functions? Yes ☐ No ☑

Name: — Relationship: —

INFORMED CONSENT

Are you prepared to make a commitment to the treatment program explained to you by the therapist?

Yes ☒ No ☐ Initial:

If you have an upper body oedema, the therapist will need to work on the chest area in order to provide effective care. Do you consent to treatment of your chest area?

Yes ☒ No ☐ Initial:

If you have lower body oedema, the therapist will need to work on the upper medial thigh and buttock area. Do you consent to treatment of these areas?

Yes ☒ No ☐ Initial:

I have read this additional case history form and have answered all questions to the best of my knowledge. I hereby give permission for the therapist to contact my referring medical practitioner or specialist.

Signature of Consent: ..... Date: 19/8/25

THERAPIST USE ONLY

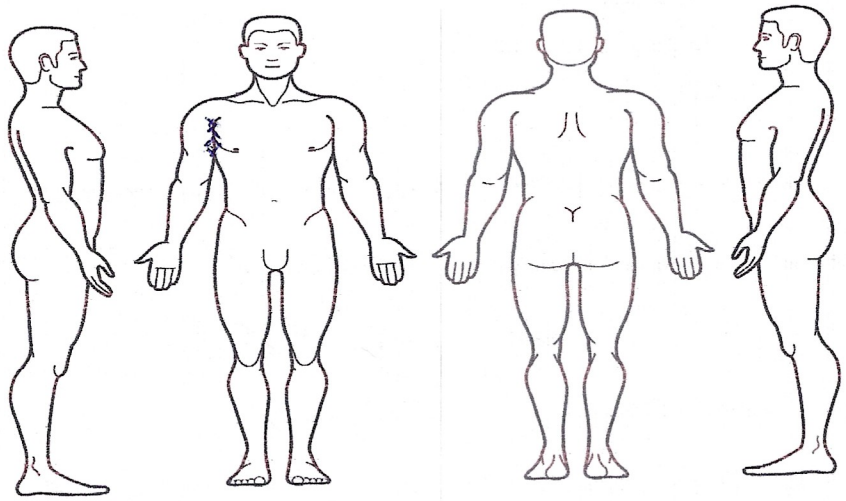
Brief description of case: .....

.....

.....

.....

CODE: Fibrosis Radiation Oedema Scar Scar Contracture Pain



✓ 1a LN Removed.
R Axilla. Numbness.