Health History:

Please tick all conditions that apply **now**.

	Condition		Condition		Condition
	Abdominal or digestive problems		Fibromyalgia		Muscle, bone injuries
	Allergies		Headaches or migraines		Numbness or tingling
	Arthritis		Hearing problems		Phlebitis
	Asthma or lung conditions		Heart, circulatory problems		Pregnancy
	Blood clots		Hernias		Rash, athletes foot/tinea
	Cancer / Tumors		High / Low blood pressure		Seizures
	Chronic Fatigue		Infectious disease		Skin disorders
	Chronic pain		Lymph node removal		Stroke
	Depression		Motor vehicle accident / trauma		Varicose veins
	Diabetes		Muscle or joint pain		Vision problems or contact lenses
	Fatigue		Other (to be filled by practitioner		

Other conditions not listed above:

Current medications (including aspirin, ibuprofen, vitamins, herbs, homeopathic and naturopathic remedies):

Recent surgeries and dates of surgery	

Current symptoms: (location and duration or onset)

History of presenting complaint: (how it happened - position / direction etc)

Behaviour of and type of pain: (constant / with movement / with activity / sharp / shooting / dull / aching etc)

Aggravating factors: (activities / posture / stressors)	**Relieving factors:** (movement/rest/posture/heat/cold)

Previous Treatments: (include all health care types – Complementary Medicine Practitioner and / or Medical Doctor, Physiotherapist, Osteopath, Chiropractor, Dentist):

Results:

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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:____________________________________Signature:____________________________ Date:_________

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