CLIENT HEALTH ASSESSMENT SHEET - CONFIDENTIAL

Surname:	*First name:*		*Date:*
Address:			*DOB:*
Suburb:	*State:*	*P/code:*	*Sex: M / F*
Mobile:	*Home #:*		*W#*
Email:			
Health Fund:	*How did you hear about us?*		
Occupation:	*Have you seen a massage practitioner before? Y / N*		
Contact person & phone (in case of an emergency):			
Hobbies/Sports/Activities:			

Please circle and physical conditions/issues currently/previously requiring treatment e.g., Diabeties, Cancer, Varicous Veins, Blood Clots, Dizziness, Heart Disease, Infectious Skin Conditions, Hepatitis, Arthritus, Epilepsy, Joint Replacements, Neck or Spine Issues/Injuries, AIDS, Cold or Flu, High Blood Pressure, Loss of Balance, Osteoperosis.

Comment on any issues:

Please list any other current or past injuries/surgeries:

What is the pain severity on a scale of 1-10..(10 being unbearable?) 1-2-3-4-5-6-7-8-9-10

Type of pain …Dull… Ache….Sharp…Throbbing… Shooting… Burning…Tingling… Numbness…Constricted

Is this pain acute(sudden) or Chronic(over time) Acute / Chronic

What aggravates the pain?

What alleviates the pain?

Are you pregnant or trying to fall pregnant? Y / N

Do you have any allergies i.e. Skin irritations, hay fever, nuts? Y / N

If yes what are they?

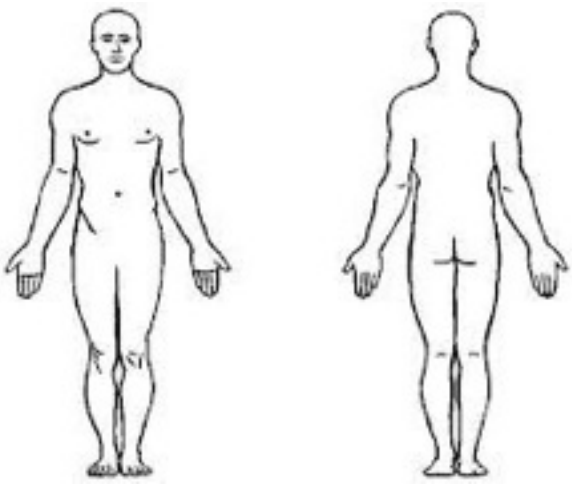
Are you currently under the care of a health care professional? If yes, please provide contact details:

Name of Dr etc:

Ph # / Location

Are you currently taking any medication? If so please list that medication and what it is for.

Please indicate areas of pain or areas requiring treatment:



CLIENT CONSENT-CONFIDENTIAL

This consent applies to the following therapies offered at Allcoast Massage: Remedial Massage Therapy, Swedish Massage Therapy, Myofascial Release, Trigger Point Massage, Lymphatic Drainage, Pregnancy Massage, Hot Stone Massage, Sports Massage, Mobile Massage, Sports Therapies, Passive Mobilisation and Traction, Corrective Exercise, Exercise Rehabilitation and Ear Candling,

I _____ understand that the treatment I receive is provided for the purpose of relaxation, relief of muscular tension or associated problems and musculoskeletal pain. If I experience any concerning pain or discomfort during the remedial treatment, I will inform the Practitioner, which will enable the Practitioner to adjust the pressure and/or strokes and/or techniques as required. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or a medical treatment. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly to the best of my ability. I agree to keep the Massage Practitioner updated as to any changes in my medical profile. I understand that there shall be no liability on the massage Practitioner or Allcoast Massage in relation to the treatment I receive. I also understand and agree that the Massage Practitioner has the right to refuse to massage a client whom he/she deems to have a condition for which massage is contraindicated or due to inappropriate behaviour.

I consent to my personal details being kept on file at Allcoast Massage and consent to them being retained in their database for use when required. I consent to my medical history and treatment notes being accessible to the practitioners who treat me at Allcoast Massage so that they may consult my notes as necessary. The ATMS code of conduct will be strictly adhered to, and I can view a copy of these policies in reception. In the promotion
of my wellbeing, should it be necessary to discuss my condition and/or treatment with my doctor or other Health Professional, I understand I shall be consulted to give specific consent for this.

Client to sign in the presence of the Massage Practitioner:

Client Signature:

Date:

Practitioner initials: