



## Remedial Massage Client History Form

### General Details

Name: ..... Today's Date: .....  
 Occupation: ..... Date of Birth: .....  
 Address: .....  
 Mobile: ..... Work: .....  
 Home: ..... Email: .....  
 Male  Female  If female, pregnant? Y  N  If so, current trimester: .....  
 Sports / Activities: .....  
 Health Insurance Provider: .....  
 Emergency Contact Name: ..... Number: .....

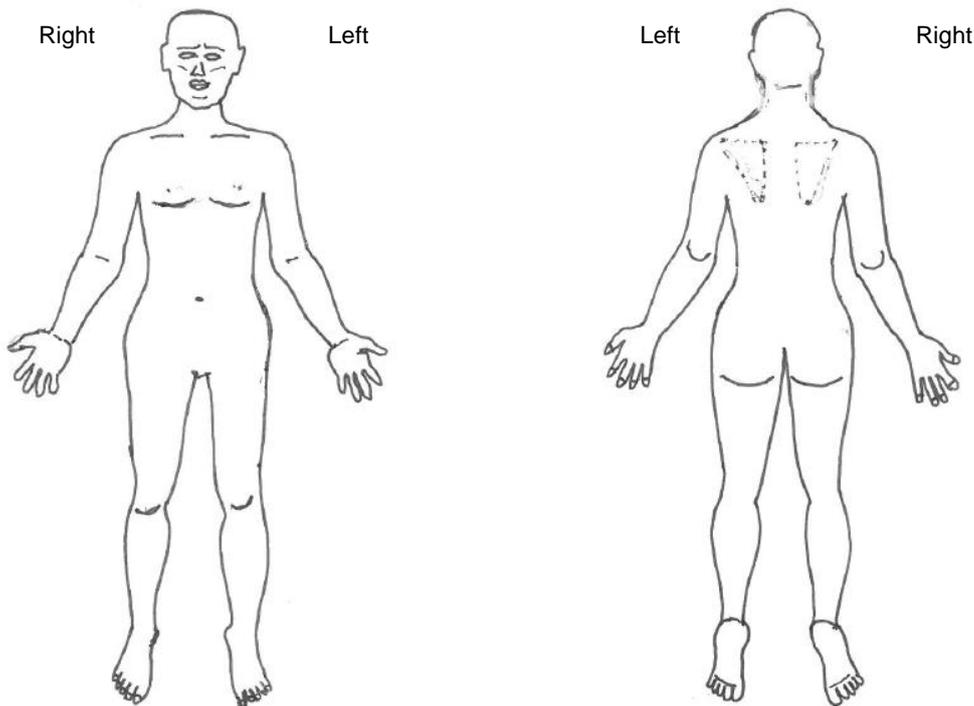
### Reasons for seeking treatment

.....  
 .....

### Presenting Symptoms

Area	Pain Intensity 1-10 (1–None, 10-Extreme)	Pain Type Sharp / Dull / Shooting Constant / Throbbing	When is it worst? Morning? Specific activity?	How long since you had this symptom?
1. ....	.....	.....	.....	.....
2. ....	.....	.....	.....	.....
3. ....	.....	.....	.....	.....
4. ....	.....	.....	.....	.....
5. ....	.....	.....	.....	.....

Using the above numbering, please locate the items on the diagrams below:



*Please  
turn  
over*



## Remedial Massage

### Medical History

#### Conditions

#### Y? Details

Cardiovascular (heart failure, DVT, etc)	<input type="checkbox"/>	.....
Kidneys (renal failure, etc)	<input type="checkbox"/>	.....
Diabetes (hyper/hypo Glycaemic)	<input type="checkbox"/>	.....
Current infections (cold, flu, STD's, etc)	<input type="checkbox"/>	.....
Digestive (bowel disease, IBS, Crone's etc)	<input type="checkbox"/>	.....
Skin conditions (infectious conditions, etc)	<input type="checkbox"/>	.....
Blood pressure (high /low)	<input type="checkbox"/>	.....
Cancer	<input type="checkbox"/>	.....
Osteoporosis / Arthritis	<input type="checkbox"/>	.....
Accidents / Injuries / Surgeries	<input type="checkbox"/>	.....
Allergies (food, oils / lotions, etc)	<input type="checkbox"/>	.....
Headaches / dizziness	<input type="checkbox"/>	.....
Any other medical conditions	<input type="checkbox"/>	.....
Medications / Supplements	<input type="checkbox"/>	.....

### Other Treatments and Outcomes

.....

.....

### How did you hear about us?

Please help us by ticking the appropriate box below.

Word of mouth                      Introduced by: .....

Referral                                Referring consultant: .....

Flyer / Leaflet                       Street Presence                       Clinic website                       Search Engine

### Client Acknowledgement and Consent

I acknowledge that:

- My therapist is not qualified to carry out a medical examination, and I agree not to interpret their comments as medical advice.
- My therapist is not qualified to provide a diagnosis, and I will not consider any advice given as such.
- Massage can produce negative effects for individuals with certain conditions, and I confirm that I have stated all my known medical conditions and answered all questions honestly. I also agree to keep my therapist updated of any changes in my conditions.
- Massage can produce short term side-effects such as light-headedness and muscle soreness.
- The actual massage treatment will be shorter in duration than the total consultation time to allow time for assessments, dressing / undressing, demonstration of stretches, payment, etc.

I consent to:

- My therapist massaging me by applying direct skin contact, using massage oils, blends or lotions.
- My medical information and treatment notes being accessed by other Ravel Therapies' practitioners.
- My medical information and treatment notes being released to other, third-party, health practitioners whom I agree for my therapist to refer me to.
- My therapist disclosing my personal information, if required to by law.
- Receiving occasional informative and/or promotional emails from Ravel Therapies.

I understand and accept the following booking and payment terms:

- Appointments cancelled less than 24 hours from the time of the appointment will incur a charge of 50% of the full consultation fee.
- Consultation fees must be paid at the time of the consultation, and can be by cash or EFTPOS.

Client Signature: .....