Level 6, 10 Bridge Street, Sydney NSW 2000
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MASSAGE THERAPIST - CLIENT HISTORY AND INFORMED CONSENT

ABOUT YOU

Name: Date:

Preferred Name: Date of Birth:

Address:

Postcode:

Phone (H): Mobile: (W):

Email:

Sex: Male ☐ Female ☐

Relationship Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Children (# of):

Emergency Contact: Relationship: Phone:

Occupation: Type of Work:

Name/location of current GP:

Allergies:

Medications/Medical History:

Reason for your visit today:

Health Fund:

Who may we thank for referring you?:

Please indicate which of the following are, or ever have been, relevant to you

- ☐ Arthritis
- ☐ Asthma or other lung conditions
- ☐ Allergies and intolerances
- ☐ Blood clots
- ☐ Cancer
- ☐ Claustrophobia
- ☐ Chronic pain
- ☐ Cold/flu/fever
- ☐ Constipation
- ☐ Diarrhoea
- ☐ Digestive conditions, IBS
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fatigue
- ☐ Fluid retention
- ☐ Hay fever
- ☐ Hernia
- ☐ Hearing problems or deafness
- ☐ Head or facial injuries
- ☐ Heart or circulatory conditions
- ☐ Headaches/ migraines
- ☐ Herpes
- ☐ High/ low blood pressure
- ☐ Infectious conditions
- ☐ Insomnia or sleep difficulties
- ☐ Joint replacements
- ☐ Jaw pain, clicking or clenching
- ☐ Kidney conditions
- ☐ Lymphoedema
- ☐ Muscle or bone injuries
- ☐ Numbness or tingling
- ☐ Neck or spine injury or disorders
- ☐ Nervousness
- ☐ Osteoporosis
- ☐ Pregnancy
- ☐ PMS
- ☐ Pain on urination or defecation
- ☐ Psoriasis
- ☐ Shingles
- ☐ Sinusitis
- ☐ Sprains and strains
- ☐ Skin conditions
- ☐ Stress or tension
- ☐ Thyroid conditions
- ☐ Tendonitis
- ☐ Varicose veins
- ☐ Vision problems or cataracts
- ☐ Weight loss or gain
- ☐ Other medical conditions

The team at Quay Health like to understand the person as a whole, not just the problem. Your health potential can be affected and influenced by your genetic predisposition and tendencies. We would like to identify any familial inheritances. Please advise if any of your immediate family have:

- ☐ Allergies
- ☐ Anaemia
- ☐ Asthma
- ☐ Cancer
- ☐ Cardiovascular conditions
- ☐ Depression or other mood disorders
- ☐ Diabetes
- ☐ Hay fever or sinusitis
- ☐ Thyroid conditions
- ☐ Other conditions

Can you relate your current health status to a specific event or injury?

- ☐ Yes
- ☐ No

Please detail……
……
Have you sought treatment to date? Please detail……
……
What aggravates your symptoms?.....
……
What relieves your symptoms?.....
……
Your weekly exercise levels……
……
Your daily water intake……

Alcohol

- ☐ Yes ☐ No

Per day……

Cigarettes

- ☐ Yes ☐ No

Per day……

Coffee

- ☐ Yes ☐ No

Per day……

Are you currently under the care of a health care professional?

- ☐ Yes
- ☐ No

Clinician's name……

Address……

Phone……

Are you currently taking pharmaceutical medication?

- ☐ Yes
- ☐ No

Name of medication……

……

……

Reason……

……

Are you taking any vitamin, mineral or herbal supplementation?

- ☐ Yes ☐ No

Reason……

……

……

Are you a member of a Private Health fund?

- ☐ Yes ☐ No

Name of the fund……

What would you like our team help you to achieve? ……

……

……

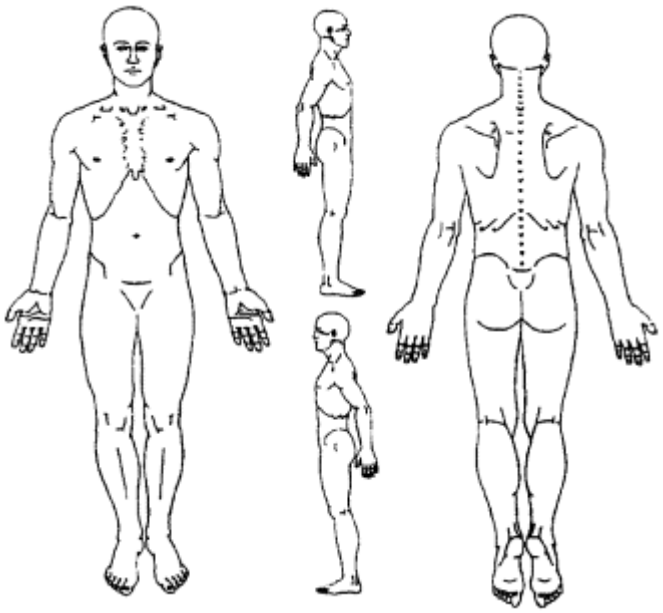
Quay Health offers a full range of health services; please indicate what areas you are interested in:

- ☐ Chiropractic health care
- ☐ Massage therapy
- ☐ Podiatry
- ☐ Herbal medicine
- ☐ Nutritional advice and diet therapy
- ☐ Fertility management
- ☐ Preconception and pregnancy care
- ☐ Children's health
- ☐ Digestive health
- ☐ Mental and emotional wellbeing
- ☐ Soul journey and sand play
- ☐ Emotional release
- ☐ Whole body care and management
- ☐ Self-help advice
- ☐ Stress management
- ☐ Lifestyle education
- ☐ Self-help advice

Please could you let us know who referred by, as we would like to thank them?

- ☐ Patient name
- ☐ Family name
- ☐ Friend name
- ☐ Website/internet
- ☐ Street name
- ☐ Other

Please mark areas of tension, stress or pain you are experiencing in the figures below



Consent for care

I acknowledge that massage is not a substitute for medical care, medical examination or diagnosis.
I have stated all my known medical conditions and I will inform my practitioner of any change in my health status. It is my choice to receive massage, I am aware of the benefits and risks, and I give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness for massage sessions. I understand that the client therapist relationship will be held in strict confidence.

Signature……..Date……