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CONFIDENTIAL MASSAGE PATIENT INFORMATION - Please complete all sections

Full name:	**Date:**
Address: Street City Postcode	
Mobile phone:	**Occupation:**
Home phone:	**Email address:**
Best time/place to contact you:	
Reminders: How would you like to be reminded of your next appointment? Email ☐ SMS ☐ Both ☐	
Date of birth:	**Age:**
Emergency Contact Name:	**Pregnant? Yes** ☐ **No** ☐
Emergency Contact Number:	**Health Fund:**
Emergency Contact Relationship:	

How did you hear about us? Eg Person (What's their name?), Facebook, Radio etc.____________________

Have you had Massage Therapy / Massage before? Yes ☐ No ☐ (If yes, what level of firmness do you like?):

Soft ☐ Medium ☐ Firm ☐ Extra Firm ☐

What other types of Massage Therapy have you had before? (eg. Deep Tissue, Remedial, Lomi Lomi, Relaxation, Sports) ____________________

____

Do you have any types of Allergies? Yes ☐ No ☐ ____________________

Health Concerns

What is the location of any current pain or problem? And what is the description? (Sharp, stabbing and / or dull)

Pain	Description	Severity (1-10)

What makes it worse?____

What makes it better?____

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐
What have you done for this condition? Was it of benefit? __________________________________

Health History - Please mark the following conditions you may have now

☐ Acute Bleeding	☐ Acute Inflammation	☐ Acute Muscle Injury	☐ Arthritis	☐ Asthma	☐ Back Pain
☐ Cold Sores	☐ Convulsions	☐ Deep Burning Pain	☐ Depression	☐ Epilepsy	☐ Extreme Pain
☐ Fractures	☐ Headaches	☐ Heart Conditions	☐ High Blood Press.	☐ Infections	☐ Joint Swelling
☐ Malignant Cancer	☐ Medical Problems	☐ Measles	☐ Mental Disorders	☐ Multiple Sclerosis	☐ Neck Pain
☐ Neurological Cond.	☐ Nervousness	☐ Restrictions	☐ Shortness - Breath	☐ Skin Conditions	☐ Stroke
☐ Thyroid Problems	☐ Torn Ligaments	☐ Tuberculosis	☐ Ulcers	☐ Other Issues	

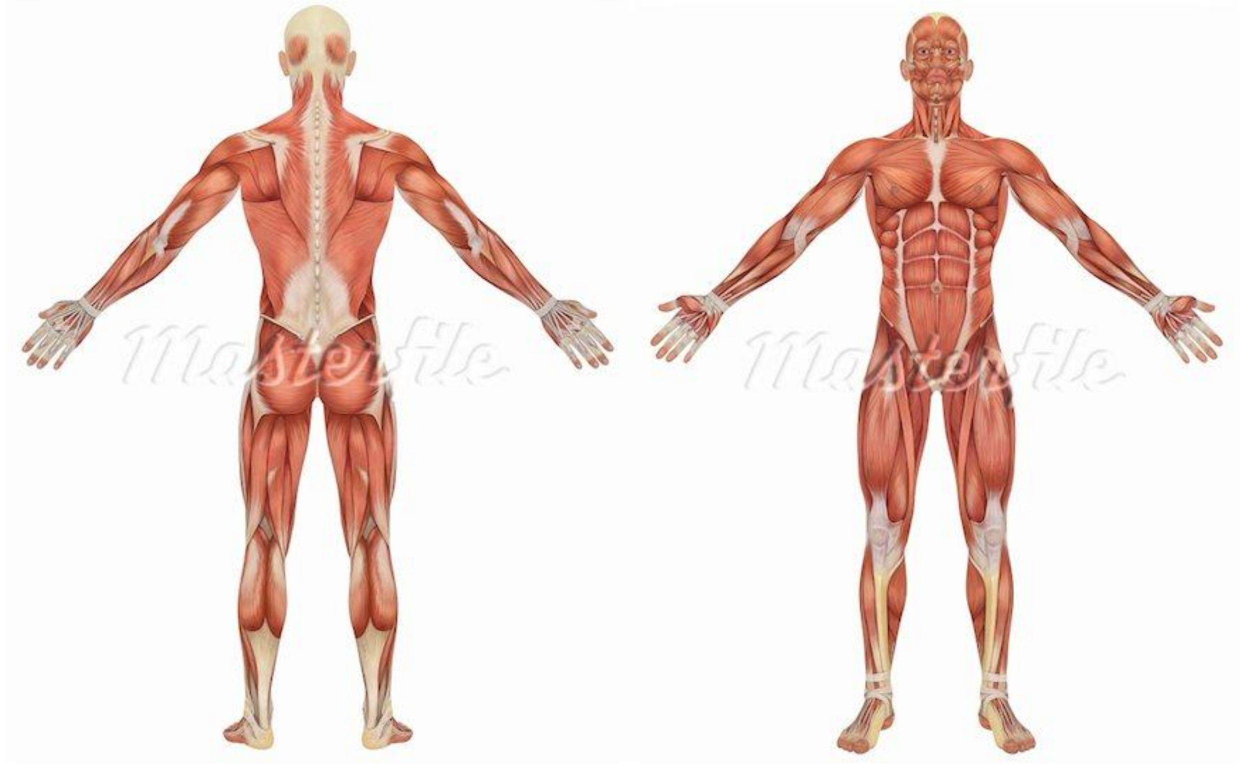
(Other – Please Explain)

____

____

Pain Identification

Please circle where you feel pain?



About Your Massage

Massage can be used for many areas of the body. Please circle any areas that you would **NOT** like to be massaged.

Face **Head** **Chest / Breast Area** **Buttocks** **Arms** **Legs** **Feet** **Front Abdomen** **Hands**

Informed Consent to Consultation:

Massage Therapy care is recognized as being an effective and safe form of health-care and healing. We pride ourselves in this office on providing all the information you need and want at all times, and hence we want to inform you of the conditions of consent to care:

The greatest care and attention will be given in all circumstances; however as with all healthcare options there are some very slight risks with massage therapy. This includes but is not limited to:

- Minor muscles aches and inflammation (like in the days after a gym workout)
- Your condition becoming worse (sometimes people feel worse while healing is occurring)

I understand that the massage I receive will be delivered in a professional manner; if I am uncomfortable at any stage throughout the treatment I will notify the therapist immediately. Massage therapist will not diagnose medical conditions and may refuse treatment if the therapist believes it may harm the client in any way. The information I have given is true and correct, I must inform the therapist if any details on this form change, so my treatments can be appropriately adjusted.

I agree to be treated by a qualified massage therapist at Massage Addiction

By signing below I agree to Massage Therapeutic Care:

Print Patient Name: ____ Date: ____________________

Signature: ____

If the patient is under 16 years of age, this form should also be signed by a parent or guardian who consents to care on behalf of the minor, and who is validly able to do so.

Parent/Guardian Name: ___________________Signature: ________________ Date: ____________________