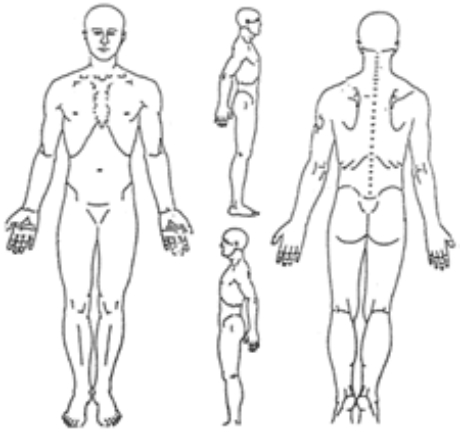
Ann Clark
Dipl. Remedial Massage Therapist
www.wamassage.com.au

Client Details

Name:	
Address:	Postcode:
Occupation:	Date of Birth: ___/___/_____
Phone:	
Email:	
Contact name and phone number in case of emergency:	
Private Health Fund (if applicable):	



Pain or Discomfort

Location of any current pain or problem: (Please mark on drawing)

How bad is the pain on a scale of **0** (no pain) to **10** (extreme)?

Type of pain/discomfort: e.g. sharp, stabbing, dull, aching

What activates or makes the pain/discomfort worse?

Have you had any massage therapy before? **YES** **NO**
How long ago did you have your last massage:

Health Conditions

Please tick the box if you currently have, or write **P** if you have previously had, any of the following health conditions. Please provide additional details, where appropriate in notes.

INJURIES

	☐ Sprain/Bruises	☐ Broken Bones / Fractures
☐ Inflammation	☐ Burns	☐ Dislocations

MEDICAL CONDITIONS

☐ Allergies: _____	☐ Epilepsy	☐ Prosthetic devices
_____	☐ Fever	☐ Rash/Skin condition
☐ Arthritis	☐ Headache/Migraines	☐ Spinal problems
☐ Asthma	☐ Heart condition	☐ Stress / Anxiety
☐ Blood Pressure High/Low	☐ Herniated / Bulging Disc	☐ Surgery
☐ Cancer	☐ Infectious diseases	☐ Swelling
☐ Depression	☐ Numbness/Tingling	☐ Varicose veins
☐ Diabetes	☐ Osteoporosis	☐ Whiplash

Are you currently seeing a doctor, naturopath or other health practitioner? **YES NO**
If so, for what condition(s)?

Are you on any medication(s)? **YES NO** If so, what kind?

For females only: Are you pregnant? **YES NO** (Indicate how many weeks)

Please list any **other** past or present medical conditions, injuries, illnesses or problems:

How did you hear about WA Massage:

Purpose for treatment today

□ Relaxation □ focus on:
□ Specific condition or problem (please provide details)
Please circle areas you want included in this treatment: Upper Back Lower Back Neck Shoulders Head/Face Arms Abdomen Legs Feet OR Full Body

Fees:

- Cancellations less than 24 hours before appointment will incur 50% of the treatment cost.
- Payment is requested at the time of service.

Privacy Policy:

- It may be necessary to discuss your condition with your doctor or referring practitioner.
- The client has the right to view their confidential client records.

Right of Refusal:

- Clients may request the massage to **stop at any stage** during the consultation.
- The therapist may refuse to treat a client for reasons of health, hygiene, medical condition or client incapacity including alcohol or drug influence.

Risks:

There is some risk associated with any treatment. The best way to reduce the chance of risk occurring is to answer all the questions about your health, fully and honestly.

Risks Associated with Massage	
Aggravate condition	Although uncommon it is possible your condition could be aggravated.
Aromatic interaction	Some oils may interact with alcohol, medications or photo-sensitive skin.
Bruising	Cupping/deep tissue may leave bruises. **NB**. Bruise easily/bleeding disorders.
Fainting	Do not skip meals before treatment. Get up slowly after massage.
Pain	Tell therapist if pain is uncomfortable or you are sensitive to stimulation.
Relaxed/Sleepy	Get up slowly. Avoid driving or using machinery. **Keep well hydrated.**

Please discuss any issues with therapist before you tick and sign this consent. Please tick the boxes, once read, sign and date this Massage Consent.

□ I (please print name) _____ verify that the client information and history . given is, to the best of my knowledge, true and accurate.

□ I undertake to advise the therapist of changes that may occur in any of my conditions at any future massage treatment that may occur.

□ I acknowledge that I understand the terms and conditions of the treatment.

□ I hereby give my consent to this treatment as discussed with the therapist.

Signature: _____ Date: ____ /____ /_____