CONFIDENTIAL

Therapeutic Treatment

CLIENT HISTORY FORM

SURNAME: _____ FIRST NAME: _____ DATE: _____

Client History

Please tick all conditions that apply (please include past conditions)

☐	Abdominal or digestive problems	☐	Fibromyalgia	☐	Muscle, bone injuries
☐	Allergies	☐	Headaches or migraines	☐	Numbness or tingling
☐	Arthritis	☐	Hearing problems	☐	Phlebitis
☐	Asthma or lung conditions	☐	Heart, circulatory problems	☐	Pregnancy
☐	Blood clots	☐	Hernias	☐	Rash, athletes foot/tinea
☐	Cancer/tumours	☐	High/low blood pressure	☐	Seizures
☐	Chronic Fatigue	☐	Infectious disease	☐	Skin disorders
☐	Chronic pain	☐	Lymph node removal	☐	Stroke
☐	Depression	☐	Motor vehicle accident / trauma	☐	Varicose veins
☐	Diabetes	☐	Muscle or joint pain	☐	Vision problems or contact lenses
☐	Fatigue	☐	Other Condition not listed		

Other Condition not listed details _____

Current medications: including aspirin, ibuprofen, vitamins, homeopathic and naturopathic remedies etc:

_____

_____

Recent surgeries:

_____

_____

Presentation

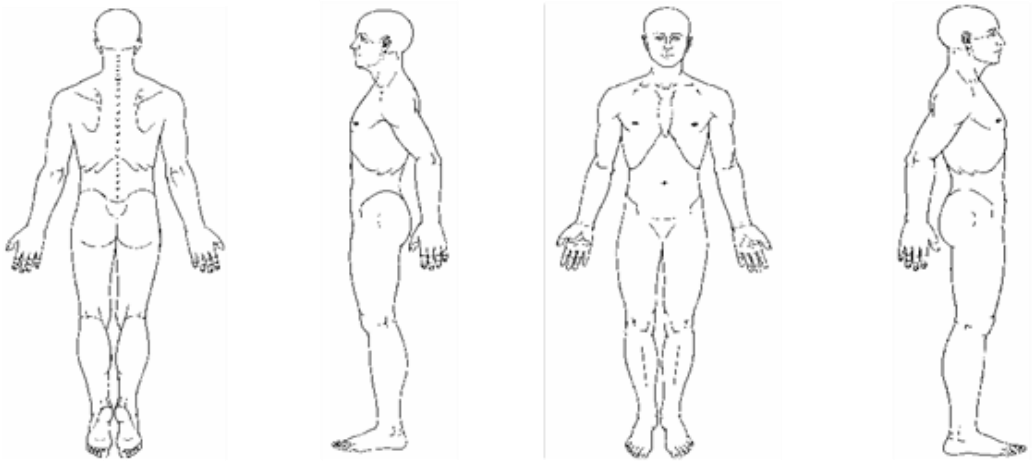
Current symptoms requiring treatment, duration or onset:

_____

_____

_____

Please indicate on the diagram below, the areas that are affected or that are painful



History of presenting complaint (how it happened/position direction etc):

_____

_____

Behaviour and type of pain (constant/with movement/with activity/ sharp/shooting/dull aching etc):

_____

_____

Aggravating factors (activities/postures/stressors etc):

_____

_____

Relieving factors (movement/rest/posture/heat/cold etc):

_____

_____

Previous Treatment:

☐	Acupuncture	☐	Deep Tissue	☐	Medical
☐	Allied Health (physiotherapy)	☐	Manual Lymphatic Drainage	☐	Naturopathy
☐	Chinese Herbs	☐	Massage	☐	Reflexology

Other (please state):

Results:_____

_____

Lifestyle Habits:

☐	Alcohol Consumption	☐	Leisure Activities	☐	Water Intake
☐	Eating Habits	☐	Smoker	☐	Work Habits (hours/day)
☐	Depression/Anxiety/Stress	☐	Sleeping Habits		

Please describe any of the above in your own words (e.g. play golf, 2 x drinks per day, feel stressed):

_____

_____

_____

Dr's name:_____Dr's contact details: Ph_____

Address _____

Treatment Goals: what would you like to achieve from the treatment?

_____

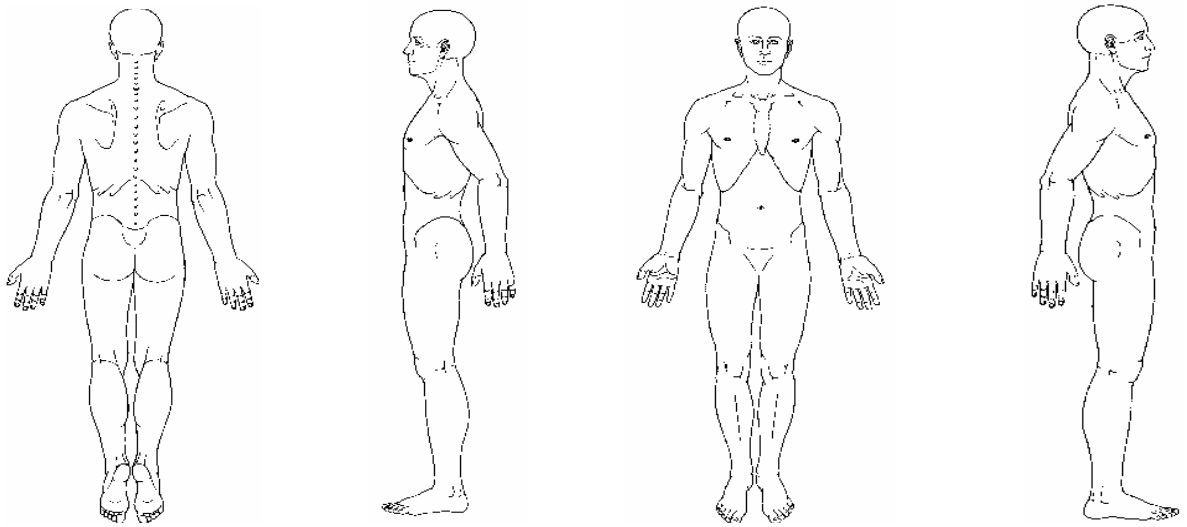
_____

Please list any points of concern you have regarding treatment (e.g. do not massage my chest, face, ears, stomach or level of undress):

_____

_____

Treatment Plan – Practitioner Use only



Contraindications/ Investigation or Referral / Treatment Summary:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Home Care: Self Care:

_____
_____
_____
_____
_____
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_____
_____
_____

Consent for Treatment

I understand that:

- This is a massage treatment and is not a medical or allied health treatment (physiotherapy, osteopathy, chiropractic)
- I have viewed the therapists' qualifications
- The risks specific to my individual circumstances may have a bearing on my decision to proceed with the proposed treatment
- The therapist reviewed my health history before treatment commenced
- The therapist explained that the physical assessment I received may involve partial undressing and may require the therapist to palpate (touch) the area(s) of my body relevant to my presenting condition
- The therapist will explain the treatment options to me and give me choice
- The therapist explained the associated risk and possible side effects with the treatment options as described
- The therapist discussed the massage procedures, the areas of the body to be treated, the undressing and dressing procedures, the draping procedures and the positioning on the table for and during treatment
- The therapist established that the treatment session will be stopped should the treatment as first agreed to, require modification. The therapist will explain the reason for the change and any risks and/or side effects as a result of the change
- I can ask any questions in regard to any modification to the treatment plan. I should be totally comfortable with the explanation and reasoning for the change before consenting to the modification to the initial treatment plan
- The therapist has explained that I have the right to refuse treatment, to make changes to the treatment and to stop the massage at any time
- I have the right to request evidence for treatment that may include the abdomen, anterior and lateral chest, and buttock and / or groin areas. I understand I have the right to refuse treatment of these areas
- If I agree to treatment to any of the areas mentioned in the point above, I may be requested, by the therapist, to complete a specialised consent form relevant to those areas

Only sign below if the above information is understood and has occurred

Client

Name:_____Signature:_____ Date:_____

Parent/Guardian

Name:_____Signature:_____ Date:_____

Therapist

Name:_____Signature:_____ Date:_____

Ongoing Treatment Record

Date	Presenting Condition	Treatment Plan	Clinical Notes/Summary	Consent
/ /				
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