Contact Details:	**Date of Birth:**

Emergency Contact Details:

Previous Massage Treatment:	**Yes**	**No**

Dr's name:	**Dr's contact details:**
Other Allied Health Professional:	**Contact details:**

General Health Screen

Weight:	**Height:**

Lifestyle Habits:

Alcohol consumption (glasses /week):	Eating habits:	Emotions:
Water consumption (glasses /day)	Smoker (#/day)	Sleeping patterns:
Leisure activities/level of exercise:		Type of Employment and Work Habits:

Previous Diagnostic / Surgical / Illness / Accidents:

Date	X-rays/investigations	Operations	Illnesses	Accidents	Other injuries

Health History:

Please tick all conditions that apply **now**.

	Abdominal/ 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 / Tumors		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/contact lenses
	Fatigue		Other (to be filled by practitioner)		
Other conditions not listed above:					

Current medications (including aspirin, ibuprofen, vitamins, herbs, homeopathic and naturopathic remedies):	
Recent surgeries and dates of surgery	
Current symptoms: (location and duration or onset)	
History of presenting complaint: (how it happened - position / direction etc)	
Behaviour of and type of pain: (constant / with movement / with activity / sharp / shooting / dull / aching etc)	

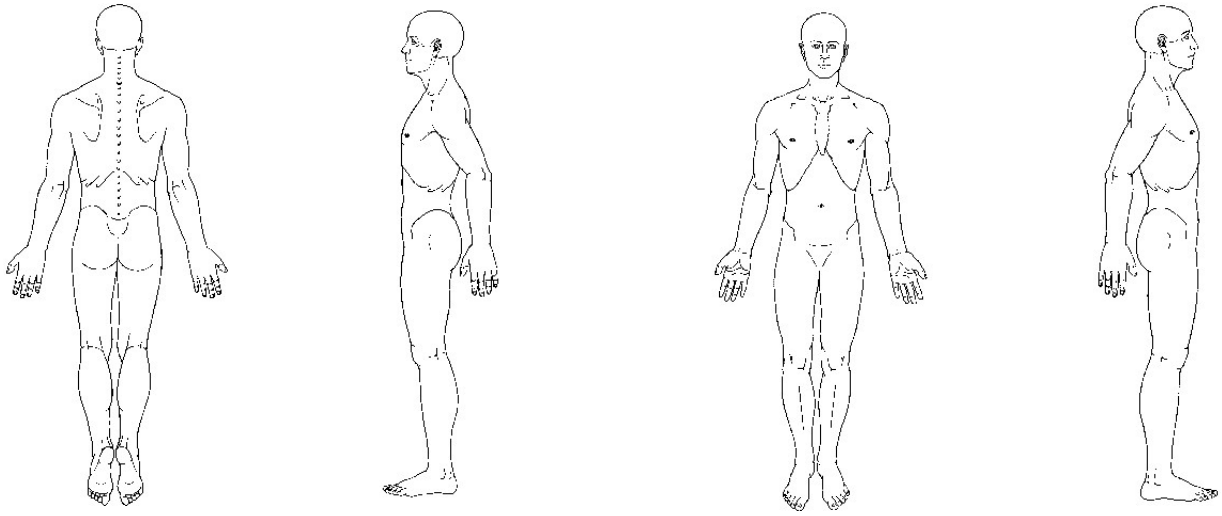
Aggravating factors: (activities / posture / stressors)	**Relieving factors:** (movement/rest/posture/heat/cold)

Previous Treatments: (include all health care types – Complementary Medicine Practitioner and / or Medical Doctor, Physiotherapist, Osteopath, Chiropractor, Dentist):
Results:

General Screen and Assessment – Therapist Use Only

Gait Assessment:

Observation & Palpation of Posture: (include major areas of asymmetry pain tension & tone)



REGIONAL EXAMINATION

Assessments should be performed at initial consultation

NB: Members are advised that some States and Territories Legislation may prohibit these tests being performed due to the scope of Allied Health providers. Please check relevant Legislation in your State or Territory and ensure you apply only what you have been trained in and that you act within your Scope of Practice, the Massage & Myotherapy Code of Ethics and the National Code of Conduct for Health Workers.

Area	Active ROM	Pre treatment	Result (+ve / -ve)	Post treatment	Result
	Passive ROM	**Pre treatment**	**Result (+ve / -ve)**	**Post treatment**	**Result**
	Resisted Test	**Pre treatment**	**Result (+ve / -ve)**	**Post treatment**	**Result**

Special Tests: refer to list attached (appendix 1)

Safety Issues / Contraindications:

Red Flags	**YES / NO**	
Further Investigation Required	**YES / NO**	
Referral Required	**YES / NO**	

Possible Risks and Complications – advice to client given

What adaptions to the treatment will you make for any presenting pathological conditions?

Treatment Goals & Proposed Treatment

Evaluation of Treatment

Re- Assessment Findings: (first return visit)

Ongoing Treatment and Aftercare:

Home Advice:

Exercise Plan:

Stretching Plan:

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 explained the treatment options to me and has given 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 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:_____

Appendix 1 Special Tests that can be included, but not limited to, are;

Cervical	**Findings**
Empty can test	
Cervical Compression test	
Cervical Distraction test	
Thoracic Outlet test	
Hautant's Vertebral Artery Test (VAO)	
Shoulder	
Thoracic Outlet test	
Hawkins Impingement test	
Empty Can	
Speeds or Yergasons	
Apley's Scratch Test	
Elbow Wrist and Hand	
Varus/Valgus stress Test	
Lateral and Medial epicondyle test	
Tinels/ Phalens test	
Thoracic	
Slump Test	
Lumbar	
Valsalva	
Pelvic Symmetries ASIS/PSIS	
Straight Leg Raise	
Lumbar Quadrant Test	
Pelvic	
Thomas test (modified)	
Patrick or Faber	
Obers	
Leg length	
Stork or Gillet test	
Trendelenberg Sign	
Knee	
ACL drawer test	
Ankle and Foot	
Ankle ligament anterior drawer test	

Surname: **First Name:**

Date	Presenting Condition	Assessment	Treatment Plan	Consent
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