

CONFIDENTIAL
CLIENT HISTORY FORM

Therapeutic Treatment

Client History

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

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

Other Condition not listed details

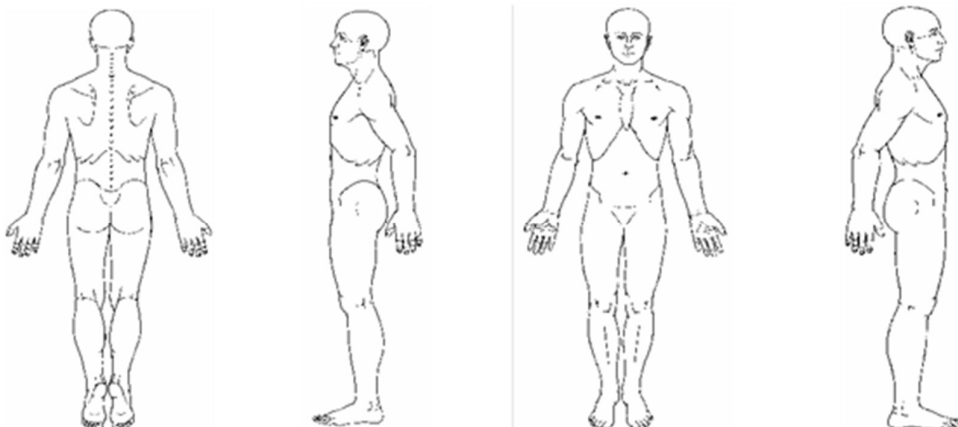
Current medications: including aspirin, ibuprofen, vitamins, homeopathic and naturopathic remedies etc:

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



Surname _____

First Name _____

Date: _____

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:

<input type="checkbox"/>	Acupuncture	<input type="checkbox"/>	Deep Tissue	<input type="checkbox"/>	Medical
<input type="checkbox"/>	Allied Health (physiotherapy)	<input type="checkbox"/>	Manual Lymphatic Drainage	<input type="checkbox"/>	Naturopathy
<input type="checkbox"/>	Chinese Herbs	<input type="checkbox"/>	Massage	<input type="checkbox"/>	Reflexology
Other (please state):					

Results: _____

Lifestyle Habits:

<input type="checkbox"/>	Alcohol Consumption	<input type="checkbox"/>	Leisure Activities	<input type="checkbox"/>	Water Intake
<input type="checkbox"/>	Eating Habits	<input type="checkbox"/>	Smoker	<input type="checkbox"/>	Work Habits (hours/day)
<input type="checkbox"/>	Emotions	<input type="checkbox"/>	Sleeping Habits		

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

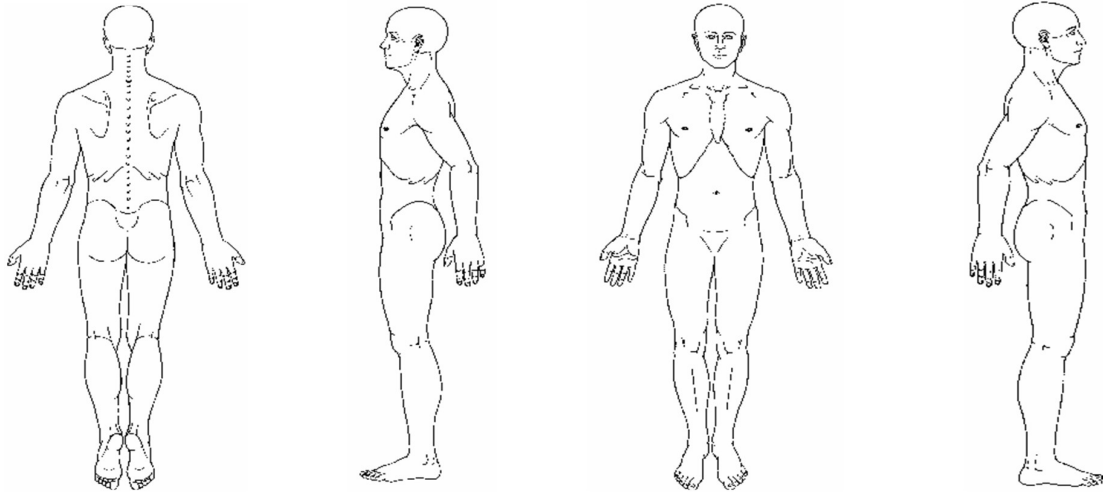
Dr's name: _____ Dr's contact details: Ph _____

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:

Possible Risks and Complications – advice given to client:

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	Consent
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