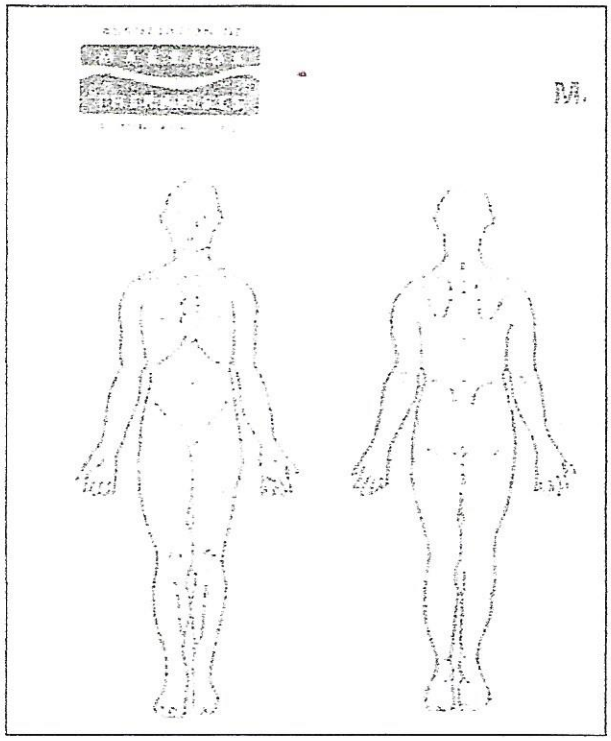
Massage Client Record



Name

Address

Postcode **D.O.B** **Gender**

Referred By **Home Phone**

Mobile Phone **Occupation**

Current Doctor

Past Medical History: _____

_____

Medications – Prescribed or Natural: _____

Presenting Symptoms: _____

History of Present Problem: _____

Activities / Hobbies / Exercise: _____

Description of Pain: _____

Amount of Pain (1-10) ___ What aggravates Pain? _____ What alleviates Pain? _____

Tick any of the following conditions that apply to you <u>today</u>:

☐ Allergies / Asthma	☐ Any contagious disease	☐ Any Skin Problems	☐ Bruising	☐ Contact lenses
☐ Drugs / Medication	☐ Headaches	☐ Heart disease	☐ Numbness / Tingling	☐ Pain / Stiffness
☐ Pregnant	☐ Breathing	☐ Recent illness / Surgery	☐ Spinal Back Problems	☐ Varicose Veins

Do you experience any difficulty lying prone or supine (front or back)? Y N

Any other conditions that may affect the massage? _____

Contact name and number in case of emergency _____

Massage may include face, head, chest, stomach, back, buttocks, arms legs and feet depending on the area of the problem. Please circle any areas you would like to have deleted from the massage.

Massage Practitioners are not qualified to diagnose or treat illness or disease or the perform thrust manipulation.
Massage does not take the place of medical treatment where needed. If you are in doubt, please consult your doctor.

Signed _____ Date ___/___/___

PLEASE NOTE THAT A MISSED APPOINTMENT WITHOUT A MINIMUM 2 HOURS NOTICE WILL BE CHARGED FOR