



naturallywell
REMEDIAL MASSAGE

ALi WHiTE REMEDIAL MASSAGE

CONFIDENTIAL CLIENT INFORMATION

SURNAME:.....**DOB:**/...../.....

GIVEN NAMES:.....**SEX:** M/F.....

ADDRESS:.....

.....**P/C**.....

PH:(H).....**(W)**.....**(M)**.....

EMAIL:.....

OCCUPATION:.....

HOW DID YOU FIND OUT ABOUT US?.....

Private Health Fund:.....

Is this your first massage? Y/N When was your last one?.....

Other current treatment: Chiro, Osteopath, Physio, GP, Specialist, Dietician, Naturopath?

Do you suffer headaches? Y/N How often?..... From neck or forehead?.....

What is your daily H2O intake?.....glasses per day.

Sporting Activity/Exercise..... X per week. Specify type.....

Blood Pressure: High Normal Low Unknown

Allergies?: (in particular oils, fragrances).....

Do you take prescription/non prescription or herbal medications? Y/N

Which one?.....What for?.....

Any major or recent surgery ? Y/N Details.....

Have you had any major falls, breaks or illnesses?(include car accidents).....

Details:.....

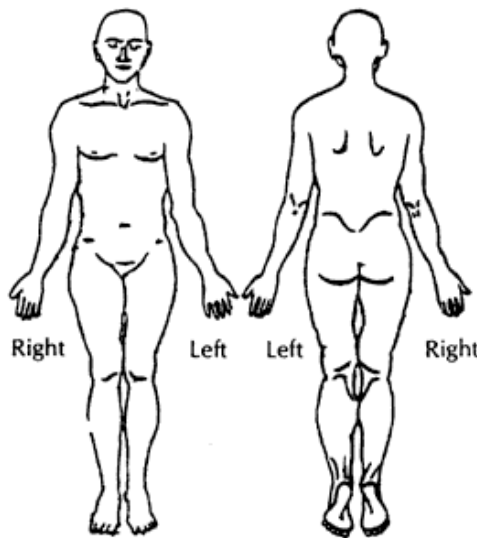
Are you pregnant? If so, how many weeks?

Do you have an infectious disease (ie tinea, herpes, hepatitis)?.....

Do you suffer any of the following?

- Dizziness Numbness Arthritis Pins & Needles Cancer Asthma
 Sciatica Depression Scoliosis Back Pain Epilepsy Heart disease
 Other

Details:



INFORMED CONSENT – Remedial Massage

I (name) _____ understand the policies and procedures of Naturally Well Health Centre. **Alison White** has informed me of her qualifications, the kind of massage services to be provided, the benefits, risks and the goals of the session(s) that we have agreed upon. I understand that I regain the right to withdraw my consent at any time during any session.

I (name) _____ understand that the massage services provided by **Alison White** are intended to promote relaxation and circulation, and relieve stress muscle tension, spasms and related pain. I understand that the remedial massage therapist does not diagnose illness nor prescribe medical treatment or perform spinal manipulations.

I have informed the therapist of my medical and physical condition and of medications I use, and I agree to update the therapist of any changes in my health profile. I release the therapist of any liability if I fail to do so.

If I experience any discomfort or pain during any session, I will immediately inform the therapist so adjustments can be made to the treatment.

The information I have given is true and correct and I understand that massage therapy is of a therapeutic nature. I am responsible for seeking my own medical advice if suggested.

Client Signature _____ Date _____