SYDNEYELITE MASSAGETHERAPY

CLIENT HEALTH HISTORY

Name_____ Gender: M / F D.O.B. _____

Address_____ PC _____

Ph (H)_____Ph (W)_____ Ph (M)_____

Email _____

Occupation_____Referred By_____

What activities (exercise/sport/hobbies) do you take part in away from work? _____

_____

Is this your first massage ever? Y / N

Have you ever had or do you currently have any of the following? (Place a tick to indicate "YES")

Flu / cold / fever	☐	High or low blood pressure	☐	Diabetes	☐
Dizziness	☐	Heart, circulatory problems	☐	Liver condition	☐
Chronic pain	☐	Abdominal or digestive problems	☐	Kidney condition	☐
Headaches	☐	Varicose veins	☐	Rash, Athletes Foot/Tinea	☐
Insomnia	☐	Raised cholesterol	☐	Skin disorders	☐
Sleep apnoea	☐	Blood clots	☐	Shingles	☐
Epilepsy	☐	Phlebitis	☐	Broken bones	☐
Stroke	☐	Asthma or lung condition	☐	Osteoporosis	☐
Arthritis	☐	Motor vehicle accident	☐	Joint injury/replacement	☐
Depression	☐	Chronic fatigue syndrome	☐	Spinal injury	☐
Allergies	☐	Infectious condition/disease	☐	Cancer/tumours	☐
Numbness	☐	Pregnancy	☐	Muscle/ligament injury	☐
Loss of Balance	☐	Gout	☐	Fibromyalgia	☐

If you ticked yes or have another please give details:_____

_____

List any recent injuries or medical treatment/surgery:_____

_____

Please state any medication you are currently taking: _____

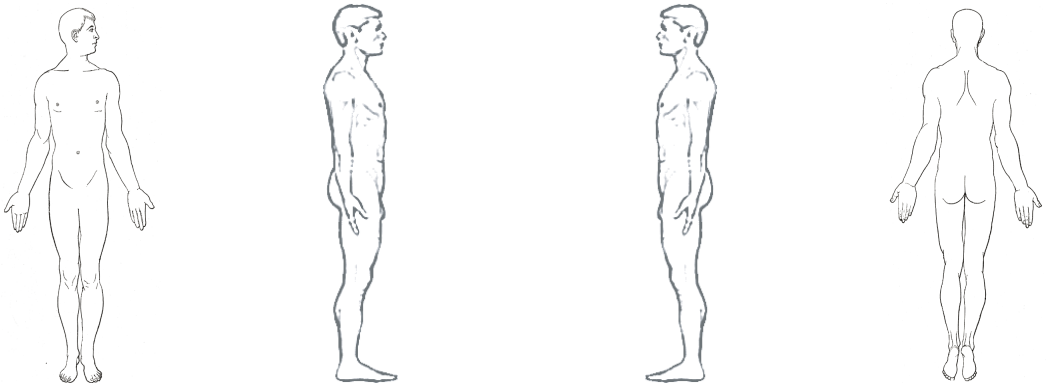
Initial Assessment *(Therapist to fill in.)* ***Consultation Date:***_____

Primary condition:_____

Other requests:_____

Aggravation: _____

Alleviation: _____



Initial notes:_____

_____

_____

_____

SYDNEYELITE
MASSAGETHERAPY

IMPORTANT INFORMATION

This form applies to massage therapy service provided at any of our clinics. Please read thoroughly, tick the adjacent box to acknowledge you agree, then sign and date at the bottom.

Payment and Cancellations

- ☐ Full payment of fee is required on day of consultation.
- ☐ If I cancel my appointment on the same day it is scheduled I will be charged a ***$30 cancellation fee***. The cancellation policy is in place to make sure appointments are kept available for others who need them and that you respect the Therapist's time.
- ☐ If I fail to show up to my appointment, I may be charged the ***full (100%) consultation fee.***
- ☐ We appreciate that sometimes life can be unpredictable and short notice may be unavoidable, in such cases discretion will be exercised.

Informed Consent and Waiver

- ☐ I understand that a Therapist does not diagnose disease, illness, or prescribe any treatment or drugs, nor do they provide spinal manipulation.
- ☐ I understand that there is always some risk associated with any treatment. The best way to reduce the chance of risk occurring is to answer all the questions asked (on this form and verbally from the Therapist) about your health, honestly and in detail.
- ☐ I understand that the Therapist will explain the treatment before they commence, however I will ask if I require further explanation or have specific questions.
- ☐ I understand that draping will be used at all times. If I become uncomfortable for any reason that I may ask the Therapist to end the massage session, and they will end the session.
- ☐ I understand that the Therapist may end the session for any inappropriate behaviour.

Privacy Statement

Any information that is obtained regarding my current health and progress will be treated as privileged and confidential and will not be provided to any person other than my physician or other relevant health care professionals without my expressed written consent.

- ☐ We collect personal information when we provide our services to you. Generally, if appropriate, we will tell you why we are collecting personal information and how we plan to use it or these things will be obvious when we collect the information. We usually collect personal information such as your contact details, job title or position, interests and where relevant family details. When we collect sensitive information (as defined in the Privacy Act) such as health information, it will usually be for the purposes of providing our services and, if the law requires us to, we will collect it with your consent.
- ☐ We use your information to provide our services and to enhance and develop our relationship with you. We keep personal information safe from misuse, loss or unauthorised use or disclosure by implementing a variety of security measures. If you would like more information about our approach to privacy, would like to ask for access to your information or if you have a complaint please contact Sydney Elite management. We may deny your request for access in some circumstances, if we do this we will tell you why.

If there is a change in my physical or mental health I will discuss and update the necessary information with my massage therapist immediately. I warrant that all information I have provided on this form and attached annexure is true and correct. I have read, agreed and understand the foregoing important information to receive treatment with Sydney Elite Massage Therapy.

I have stated all of the conditions that I am aware of, and this information is true and accurate.

Signature …… Name ……

Date .....

If client is under 18, a parent or guardian's signature is required.

I, ... am the parent / guardian of ..... and agree to be responsible for the their behaviour and confirm that I give permission for them to receive treatment from a Sydney Elite Massage Therapist. I personally accept the foregoing important information.

Parent/Guardian Signature …… Parent/Guardian Name……

Date .....