MASSAGE CLINIC QT
Road to Recovery

CONFIDENTIAL

CLIENT HEALTH QUESTIONNAIRE
Assessment & Treatment Consent

Name: …..... **Home Phone:**…....

Address: …..... **Work Phone:**.....

…..... **Mobile:** …....

…..... **Email:**…....

Occupation: …..... **Date of Birth:**.....

Emergency Contact: …..... **Relationship:** ..... **Phone:** .....

Where did you hear about Massage Clinic QT?

☐ LWB ☐ Website ☐ Friend/Relative ☐ Google ☐ Practitioner Referral (specify) ….....

☐ Mountain Scene ☐ Adverstising Flyer ☐ Facebook ☐ Yellow pages ☐ Other (specify) .....

What is your current issue? ….....

Is this getting: Worse ☐ Better ☐ Comes and goes ☐

Please tick if you wear: Dentures: ☐ Hearing Aid: ☐ Contact Lenses: ☐

Height: …..... **Weight:** ….....

Have you had Massage Therapy before? Regularly ☐ Occasionally ☐ Never ☐

Please note below any current conditions, medical history or family history (tick if applicable). A thorough assessment of the body enables the practitioner to make the best therapeutic decisions for your treatment.

Cold or influenza		History of Thrombosis/DVT		Short of breath	
Inflammation		Immune condition		OOS/RSI/Carpal tunnel	
Infection		Hepatitis C/HIV		Strain/Sprain - Grade:	
Fever/Swollen glands		Haemophilia		Sciatica	
Contagious Disease		Cancer/past treatment?		Spinal disc pathology	
FEMALES:Are You Pregnant?		Aneurysm		X-ray/MRI of Spine? Date:	
Allergies:		Heart problems / Pacemaker		Metal implants – rods/screws	
Arthritis		Chest Pain		Fractures – where?	
Diabetes		Stroke		Joint Replacement/dislocations	
Osteoporosis		High/Low blood pressure		Jaw pain/grinding teeth/TMJ	
Seizures/Convulsions		Poor Circulation		Numbness/Tingling	
Headaches/migraines		Varicose Veins		Pain *	
Fungal infections		Multiple Sclerosis (MS)		Stiffness *	
Psoriasis/Eczema/sensitive skin		Hernia/Ulcer		Restricted movement *	
Sinusitis – current?		Crohn's Disease/IBS		* Where?	
Dizziness		Digestive problems		Neck /Back Problems?	
Bruise easily		Respiratory problems		Hip/Leg Problems?	
Fluid retention		Asthma		Shoulder/Arm problems	

Have you had any serious or chronic illness, operations, injuries or traumatic accidents in your lifetime? YES/NO If yes, please explain and include date(s):

…..
…..
…..
…..
…..
…..

Please list all medications you currently take - if you can't remember the name note the condition the medication is treating: .....
….....

Are you currently or have you at any time within the last 12months been under care of a doctor?
YES / NO If so for what condition?: .....

Do you have clearance from your doctor to receive Massage Therapy?
YES / NO / UNSURE / NOT APPLICABLE

If needed does Massage Clinic QT have your permission to contact your doctor? YES / NO

GP's Name: …..... Practise .....

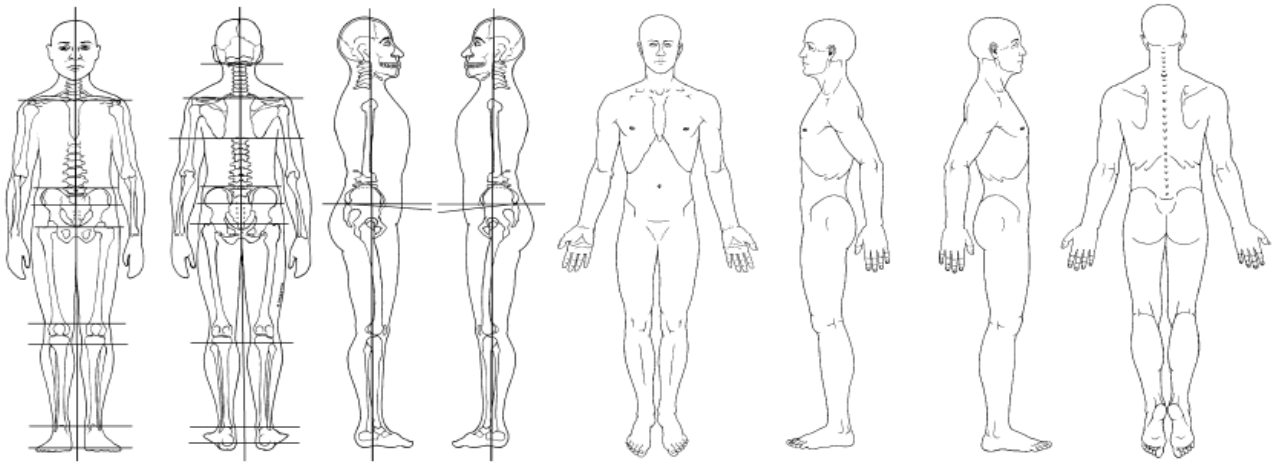
Please indicate current level of pain/discomfort on a scale of 1 to 10 below:

1 2 3 4 5 6 7 8 9 10

no pain unbearable pain

Does your complaint limit your sleep/work/daily routine? YES / NO.....

Please circle any areas of pain or tenderness



List any Exercise/Sport: .....

How often: .....

Please circle if consume	Coffee + / - Sugar	Tea + / - Sugar	Carbonated Drinks	Alcohol	Tobacco
Daily intake:					

Disclaimer:

I have completed this health form to the best of my knowledge and have stated all my known physical & medical conditions and medications I am taking and I will keep the Massage Therapist updated on any changes.
I understand that Massage Therapy services are a therapeutic health aid and they do not diagnose illness, disease or prescribe medical treatment or phamaceuticals, nor are spinal or other manipulations part of massage therapy. I understand that massage therapy is not a substitute for a medical examination/care and that it is recommended that I am concurrently working with my primary caregiver for any condition I may have.

If I am not able to make a scheduled appointment, I agee to cancel the appointment 24 hours in advance by phone/email unless I have an emergency, in which case I will call ASAP to reschedule my appointment. If I fail to give notice and not arrive for my scheduled appointment then I agree to pay the full cost of the session time booked.

Informed Consent to Assessment and Treatment:

I understand that in order to receive treatment I maybe initially assessed prior to treatment. Following the assessment I will be provided with an explanation of the treatment to be given and I have the right to ask questions if I do not understand.
I understand that I can decline assessment and treatment at any time.

Client's Signature:..... **Date:** ….....