

PATIENT HISTORY FORM

Patient Details:

Name Date of Birth Identify as: M () F ()
 Emergency Contact: Name Relationship Phone

Contraindications & Medical History:

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|---|-----|----|-------------------------|-------|-----|----|
| 1. Is there a possibility you are pregnant?
If yes, how many weeks? _____ | Yes | No | | | Yes | No |
| 2. Do you have any difficulty lying on your front, back or side?
If yes, please explain: _____ | Yes | No | | | Yes | No |
| 3. Varicose veins | Yes | No | 12. Skin diseases | | Yes | No |
| 4. Sunburn | Yes | No | 13. Allergies | | Yes | No |
| 5. Recent surgery/scar tissue | Yes | No | 14. Diabetes | | Yes | No |
| 6. Major operations/accidents | Yes | No | 15. DVT/blood clots | | Yes | No |
| 7. Inflamed/painful areas | Yes | No | 16. Fractures/sprains | | Yes | No |
| 8. High/low blood pressure | Yes | No | 17. Raised temperature | | Yes | No |
| 9. Pacemaker | Yes | No | 18. Headaches/migraines | | Yes | No |
| 10. Circulatory disorders | Yes | No | 19. Medications | | Yes | No |
| 11. Supplements | Yes | No | | | | |
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I (patient name) understand and agree to the following:

I understand that the massage or bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage or bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage or bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

My confidential information is treated in accordance with the Health Records and Information Privacy Act 2002 (NSW).

Signed: Date: