Informed Consent

Full Name: _____

I understand that the massage/bodywork I receive is for the basic purpose of stress reduction and relief from muscular tension, spasm or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform the massage/bodywork professional so that the pressure and/or methods/strokes can be adjusted to my comfort level.

I understand that massage/bodywork professionals do not diagnose illnesses or diseases or perform any spinal manipulations, nor do they prescribe any medical treatments, and nothing said or done during the session should be construed as such. I acknowledge that the massage is not a substitute for medical examination or diagnosis or treatment and that I should see an appropriate healthcare provider (e.g. chiropractor, physiotherapist) for those services.

I understand that a single massage session or massage used on a random basis is limited to providing a general, non-specific massage approach using standard massage methods and does not include any methods to address soft tissue structure or function specifically.

Massage may include the head, face, neck, chest, stomach, arms, hands, back, lower and upper buttocks (sciatic nerve), legs and feet depending on the area presenting with a problem. Please indicate any area that you would like to have deleted from the massage/bodywork.

Everybody responds to treatment differently. Some reactions and/or elimination warnings following the massage/bodywork may include increased urination, darker and/or stronger smelling urine due to the elimination of toxins, flatulence and/or frequent bowel movement, dizziness, nausea, aggravated or improved skin, deeper/disturbed sleep, headaches, tiredness/increased energy, feeling hungry, feeling emotional with subjective mental perceptions that are unique to the individual.

Because massage/bodywork should not be performed under certain circumstances and medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the massage practitioner updated as to any changes in my health and medical profile, and I release the massage professional from any liability if I fail to do so.

It is also understood 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 "full" scheduled appointment.

I have read and understand the above and I am receiving treatment on my request.

_____	__/__/__	_____
Patient Signature	Date	Therapist Signature

Consent to treat a minor:

By my signature I authorise Klára Sandoval to provide massage/bodywork to my child or dependent.

_____	__/__/__
Patient Signature	Date

Klára Sandoval
REMEDIAL MASSAGE THERAPIST
0404 437 378

19 Highland Drive,
Seventeen Mile Rocks, QLD 4073
therapeutichands.com.au

ATMS Accredited and
Fellow Member: 21727
ABN: 42 553 763 037

Confidential Patient History

Full Name: _____ Today's Date: ____/____/____

Address: _____

Email Address: _____ Mobile: _____

Date of Birth: _____ Age: _____ Gender: _____

Dependents: _____ Ages: _____

Next of Kin: _____ Mobile: _____

Occupation: _____ How long: _____

Referred by: _____

Current GP: _____ Phone: _____

Health Fund: _____

Have you had any previous experience with massage? ☐ Yes ☐ No

If Yes, what type/s? _____

Have you had any previous experience with other alternate therapies? ☐ Yes ☐ No

If Yes, what type/s? _____

Primary reason for appointment / Areas of pain or tension: _____

_____

Description of pain: _____

History of present problems/symptoms: _____

_____

Have you had any previous therapy for your current condition? ☐ Yes ☐ No

If Yes, what types/? _____

When? _____ Frequency/amount of treatment _____

Specify any other conditions, imbalances or irregularities in your body and/or limbs that may affect the massage:

_____

Current medications - prescribed/natural: _____

Do you experience any difficulty lying prone or supine (on your front or back)? ☐ Yes ☐ No

Recent Illness / Surgery: _____ ☐ Yes ☐ No

_____

Illness / Surgery in the past 5 years: _____ ☐ Yes ☐ No

_____

All forms and frequencies of stress reduction, activities, hobbies, exercises or sports participations:

_____

Please indicate what type of massage pressure is prefered: ☐ Very Firm ☐ Firm ☐ Medium ☐ Medium - Light ☐ Gentle

Medical History

Please tick appropriate block as applicable

(X) All conditions that apply now
(P) Past conditions - last 10 years
(F) Family history of conditions

DESCRIPTION	X	P	F	DETAILS
Abdominal problems				
Allergies, Sensitivity				
Arthritis, Tendonitis				
Asthma / Lung problems				
Birth control, IUD				
Blood clots				
Bruising				
Cancer, Tumours				
Chronic pain				
Circulatory problems				
Constipation, Diarrhoea				
Dental bridles, Braces				
Depression				
Diabetes - Type I or Type II				
Epilepsy				
Fatigue				
Headache / s				
Hearing problems, Deafness				
Heart disease / problems				
Hernia				
High/Low blood pressure				
Unstable blood pressure				
Infectious / contagious disease				
Jaw pain, TMJ problems				
Muscle or Joint pain / stiffness				
Numbness / Tingling				
Pregnancies / nent, weeks?				
Skin problems / conditions				
Sleep difficulties				
Spinal / back problems				
Thrombosis				
Varicose veins				
Vision problems / contact lenses				
Other medical conditions not listed				

I, _____ acknowledge that all the information supplied on this form is true and correct and to the best of my knowledge. I also accept treatment for the conditions listed in the “Primary reason for appointment” section.

_____ _____ / / _____

Patient Signature Date Therapist Signature