CONFIDENTIAL REMEDIAL MASSAGE SCREENING FORM

Title eg Mr/Mrs or preferred pronouns …… Date of Birth ……/……/……

First Name …… Preferred Name ……

Last Name …… Occupation ……

Ph – Mobile …… Wk …… Hm ……

Address ……

Suburb …… Postcode ……

Email Address ……

Emergency Contact Name …… Ph ……

Your Primary GP …… Practice Name/Suburb of GP ……

How did you hear about us? ☐Physio ☐Dr ☐Health Provider ☐Word of Mouth ☐Signage ☐Internet ☐I'm a past client

Name of person who referred you ……

GENERAL HEALTH AND MEDICAL HISTORY:

Exercise Type/s ……

Exercise Frequency ☐ Rarely/Never ☐ Occasionally ☐ 1-2 days per week ☐ 3-4 days per week ☐ 5-7 days per week

Have you taken any medications or supplements in the past 2 weeks including aspirin, anti-inflammatories, vitamins or herbs?

☐ No ☐ Yes – please list ……

……

PLEASE TICK ✓ ALL CONDITIONS THAT YOU CURRENTLY HAVE OR PUT A "P" FOR PAST CONDITIONS:

___ blood clots / phlebitis	___ bone injuries	___ fatigue
___ heart / circulatory problems	___ osteoporosis	___ depression / anxiety
___ high / low blood pressure	___ arthritis	___ mental health problem
___ history of stroke	___ hernia	___ insomnia
___ cancer / tumours	___ diabetes	___ headache / migraine
___ lymph nodes removed	___ skin conditions / rash	___ vision problems
___ infectious diseases	___ surgery	___ hearing problems
___ epilepsy / seizures	___ motor vehicle accident	___ pregnant
___ abdominal / digestive problems	___ numbness or tingling	___ miscarriage
___ asthma / lung conditions	___ muscle / soft tissue injuries	___ endometriosis

___ allergies – please list: ……

DETAILS FOR ABOVE CONDITIONS and/or ANY OTHER relevant CONDITIONS, ILLNESSES, ACCIDENTS, SURGERIES:

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……

Do you currently have a contagious disease or virus? (eg cold, flu, covid-19, vomiting, diarrhoea, shingles, conjunctivitis etc)

☐ No ☐ Yes – details: ……

Are you currently having treatment for a medical/health condition?

☐ No ☐ Yes – details: ……

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TREATMENT:

Reason for seeking remedial massage treatment: ……

……

……

Brief history of current problem eg location, onset, duration, cause etc: ……

……

……

SYMPTOMS: ☐ Pain ☐ Stiffness ☐ Sharp ☐ Dull ☐ Aching ☐ Numb ☐ Pins/Needles ☐ Constant ☐ Other

Frequency of symptoms: ……

Aggravating factors: ☐ activities ☐ posture ☐ movement ☐ rest ☐ ……

Relieving factors: ☐ heat ☐cold ☐ movement ☐ rest ☐posture ☐ ……

Do you have any concerns about your treatment?

☐ No ☐ Yes – details: ……

Are there any areas you would like avoided?

☐ No but I will tell if you I change my mind ☐ Buttocks ☐ Face ☐ Stomach ☐ Chest

Do you experience any difficulty lying on your: ☐ front ☐ back ☐ side ☐ N/A

CONSENT TO TREATMENT ✓ Please tick the boxes once read.

☐ I have chosen to consult with and hereby give consent for massage treatment to be provided by Remedial Massage Therapists at Re-Balanced Bodies.

☐ I understand that I have the right to refuse, request changes to or stop the treatment at any time and I will advise the therapist if the pressure applied or any aspect of the treatment is causing discomfort.

☐ I understand that the therapist has the right to refuse to provide massage treatment if he/she deems that I have a condition for which massage is contraindicated.

☐ I understand that massage therapists are not qualified to diagnose, treat illness or disease and anything said during the course of treatment should not be construed as medical advice.

☐ I have provided a detailed medical history and do not expect the therapist to have foreseen any previous or pre-existing condition that I have not mentioned.

☐ I understand that massage may provide benefits for certain conditions such as reduced symptoms of muscle-related conditions, relaxation etc but results are not guaranteed.

☐ I understand that massage may also produce temporary side effects such as headache, mild bruising, light-headedness, muscle soreness, tiredness or increased awareness of areas of pain.

☐ I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the treatment.

☐ I consent to the conditions for collection of this information as outlined in our Privacy Policy on www.rebalancedbodies.com.au

☐ I declare that the information I have provided is, to the best of my knowledge, true and accurate.

…… ……/……/……

Client Signature (or Parent/Guardian if client under 18 years of age) **Date**

Parent/Guardian Name …… ***Office Use only:*** *Ltr*