Client Intake Form – Therapeutic Massage

Personal Information:

Name _____ Phone (Day) _____ Phone (Eve) _____

Address _____

_____

email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Date of Initial Visit _____

1. Have you had a professional massage before? Yes No

   If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying on your front, back, or side? Yes No

   If yes, please explain _____

3. Do you have any allergies to oils, lotions, or ointments? Yes No

   If yes, please explain _____

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

   If yes, please describe _____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

   If yes, please describe _____

8. Do you experience stress in your work, family, or other aspect of your life? Yes No

   If yes, how do you think it has affected your health?

   muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other _____

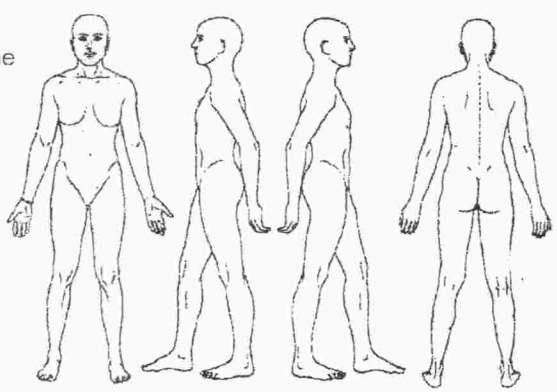
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

   If yes, please identify _____

10. Do you have any particular goals in mind for this massage session? Yes No

    If yes, please explain _____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



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Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

11. Are you currently under medical supervision? Yes No
    If yes, please explain _____
12. Do you see a chiropractor? Yes No If yes, how often? _____
13. Are you currently taking any medication? Yes No
    If yes, please list _____
14. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) Fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy If yes, how many months?

Please explain any condition that you have marked above _____

_____

_____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

_____

Draping will be used during the session – only the area being worked on will be uncovered.
Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session.
Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ (print name) understand that the massage 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 therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 that I am aware of. I understand that massage therapists 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 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____

Flex Health Professionals
90 Allnutt St
Mandurah WA 6210

P: (08) 9581 3331
F: (08) 6270 4447
E: admin@flexhp.com.au

Your Privacy: Our Policy

The provision of quality health care requires a practitioner-patient relationship of trust and confidentiality. Consistent with our commitment to quality care, Flex Health Professionals has developed a policy to protect patient privacy in compliance with current legislation.

Collection
This means we will collect information that is necessary to properly treat you. Such necessary information may include;

- Full medical history, family medical history, contact details
- Ethnicity, genetic information
- Medicare/private health fund details and billing/account details

The information will normally be collected directly from you. There may be an occasion when we will need to obtain information from other sources;

- Other medical practitioners, e.g GP's and specialists
- Other health care providers such as physiotherapists, occupational therapists, psychologists, pharmacists, dentists, nurses, hospital and day surgery units.

Both our practice staff and health practitioners may participate in the collection of this information. In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior consent.

Use & Disclosure

With your consent, the practice staff will use and disclose your information for purposes such as:

- Account keeping and billing purposes for the management of our practice
- Referral to another medical practitioner or health care provider
- Referral for further tests e.g x-rays
- Referral to a hospital for treatment options
- Quality assurance, practice accreditation and complaint handling
- To meet our obligations of notification to our medical defence organizations or insurers
- To prevent or lessen a serious threat to an individual's life, health or safety
- Where legally required to do so, such as producing records to court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases.

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Access

You are entitled to access your own health record at any time convenient to both yourself and the practice. Access can be denied where:

- To provide access would create a serious threat to life or health
- There is a legal impediment to access or if your request is frivolous
- The information relates to anticipated or actual legal proceedings and you would not be entitled to access the information in those proceedings; and
- In the interest of national security

We ask that, where possible, your request be in writing. We may impose a charge for photocopying or for staff time involved in processing your request. Where you dispute the accuracy of the information we have recorded, you are entitled to correct the information. It is our practice policy that we will take all steps to record all of your corrections, and place them with your file but will not erase the original record.

Consent

I provide my consent for the staff and practitioners at Flex Health Professionals to collect, use and disclose my personal information as outlined above.

I understand that I am entitled to access my own health records except where access would be denied as outlined above.

I understand that I may withdraw my consent as to use and disclosure of my personal information (except when legal obligations must be met).

Patient Name: _____

Signed:_____

Date: _____