Office Use: EB ❑ FB ❑ Google ❑ Other: _____ Conc ❑ Stnd ❑ Total: HICAPS $_____ Cash $_____ CC $_____

# You Relax Massage

## Confidential New Client Form

You Relax Massage
Alex van der End
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7b Alfred Grove
Oakleigh East VIC 3166
Mob: 0414 344 239

Contact Details: ❑ Dr ❑ Mr ❑ Mrs ❑ Miss ❑ Ms Date of Birth: _____/_____/_____

First Name: _____ Last Name: _____

Address: _____ Phone: _____

_____ Mobile: _____

_____ P/C: _____ Email: _____

Employer: _____ Occupation: _____

Family Doctor: _____ Emergency Contact: _____

Family Doctor Ph: _____ Relationship to you: _____

Did your Doctor, Physiotherapist, Chiropractor or Osteopath refer you today? ❑ Yes ❑ No

If so, who referred you and for what reason? _____

_____

How did you find out about us?: _____ Allergies: _____

Concession/Student: _____ Private Health Fund: _____

Do you have a Family History of the following?

❑ Heart Disease ❑ Cancer ❑ Kidney ❑ Other illness: _____

Have you ever had any of the following? If so, please provide details below.

❑ Arthritis
❑ Anxiety, Depression, Panic Disorder, or other psychiatric conditions
❑ Auto-immune condition (AIDS, chronic fatigue, lupus, etc.)
❑ Back problems
❑ Blood clots
❑ Broken/dislocated bones
❑ Bruise easily
❑ Cancer
❑ Chemical dependency (alcohol, drugs)
❑ Chronic pain
❑ Constipation/diarrhoea
❑ Diabetes
❑ Diverticulitis
❑ Dizziness or Fainting
❑ DVT – Deep Vein Thrombosis
❑ Epilepsy/Seizures
❑ Fibromyalgia
❑ Gout
❑ Glandular Fever
❑ Headaches
❑ Heart conditions, Heart murmur
❑ Hernia
❑ Hepatitis (A, B, C, other)
❑ High Blood Pressure
❑ Insomnia
❑ Liver or Kidney conditions
❑ Muscle Strain/Sprain
❑ Palpitations or Pains in the Chest
❑ Pregnancy
❑ Raised cholesterol/triglycerides
❑ Sciatica
❑ Scoliosis
❑ Skin conditions
❑ Stomach or Duodenal Ulcer
❑ Stroke
❑ Surgery
❑ TMJ disorder
❑ Whiplash
❑ Other: _____
_____

Today, do you have any of the following?

❑ Cold / Flu ❑ Skin Rash ❑ Open Cuts ❑ Injuries/Bruises ❑ Severe Pain
❑ Anything contagious ❑ Other: _____

Are you taking any medications? ❑ No ❑ Yes If so, what are you taking and for what purpose?

_____

_____

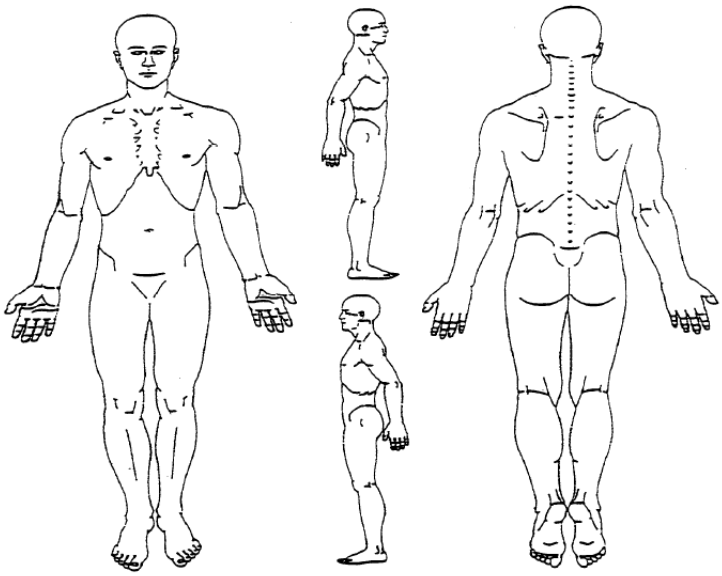
Are you currently seeing any other health care professional? ❑ No ❑ Yes (Please provide details)

_____

_____

**PLEASE NOTE:** If any of these conditions change, including pregnancy: please advise your therapist, so they may adapt your treatment accordingly. Ladies - before receiving abdominal massage you should advise your therapist if you are pregnant, menstruating or have an intrauterine device implanted.
Tick here to confirm you agree: ❑

What areas of concern do you have today? Please clearly indicate on the diagram below:



Please indicate areas you prefer **NOT** to have massaged:

❑ Hands ❑ Arms ❑ Face
❑ Head ❑ Feet ❑ Legs
❑ Glutes ❑ Pecs ❑ Other

**Your Massage Treatment – What do you want?**

❑ **GO LIGHTLY:** I just need to relax and want a gentle soothing massage [2-4/10]

❑ **FIRM WHERE IT'S NEEDED, BUT LET ME RELAX:** Please challenge my tight muscles and knots, but give me time to also relax. [3-6/10]

❑ **DEEP AND THERAPEUTIC:** Please fix my problems by focusing on the tight areas. I'll let you know if it's too strong. (ie 8/10 is too much) [5-7/10]

**You Relax Massage Information, Policy and Consent:**

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to: the need to move or change position, cramps, sighing, yawning, change in breathing, stomach gurgling, emotional feelings and/or expression, headaches, movement of intestinal gas, energy shifts, falling asleep and memories.

Prior to your massage, please feel free to remove contact lenses and all jewellery. Pull long hair back with a clip or band. Generally, massage is given while you are unclothed, but wearing your underpants. Draping with towels or other covering will be used during the massage session – only the area being worked on will be uncovered. This is **your** massage and we want **you** to be as relaxed and comfortable as possible. Please do not hesitate to ask your therapist any questions before, during or after the session. Your therapist is a trained professional and will be happy to make you feel informed and comfortable. If at any time you wish to suspend or stop the session, please feel free to let your therapist know.

Please understand that the massage you receive is provided for the purpose of relaxation, relief of muscular tension and other therapeutic benefits. If you experience pain or discomfort during the session, you are required to immediately inform your therapist so that it may be noted and the pressure/strokes may be adjusted to the right level of both the treatment goals and your comfort. If you do not let the therapist know of any discomfort, your body may well be working against you and your treatment goals may not be achieved. You will therefore not hold the therapist responsible for any pain or discomfort you experience during or after the session if you do not let them know.

You understand that the services offered today are not a substitute for other health/medical care, but may work well together with other care. You understand that your therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness. Your therapist is a qualified Remedial Massage Therapist, former Director of the Massage Association of Australian, current member of the Association of Massage Therapists, as well as author of a book on treating lower back pain, Give BACK Hope.

You affirm that you understand that your treatment is entirely therapeutic and non-sexual in nature in any way. Any sexual requests will terminate your treatment immediately and forfeit any fees paid/or due. By signing below, you hereby waive and release the therapist from any and all liability, past, present and future relating to the massage therapy.

**If the client is under the age of 15**, consent to massage therapy should be obtained from your legal parent/guardian. We prefer that your legal parent/guardian be present or available during the session. Please sign and date below to indicate that you understand this Policy.

Signed: _____ Date: _____ / _____ / _____

Name of parent / legal guardian: _____

Signed: _____

Name of favourite charity: _____

If you consent to Dry Needling or Cupping, please initial here to confirm you have given Informed Consent and understand the procedure and risks involved. ❑ Dry Needling _____ ❑ Cupping _____ ❑ Both _____