



# You Relax Massage

## Confidential New Client Form

**You Relax Massage**  
Alex van der End  
ABN: 84 798 943 195  
10 Pioneer Close  
Vermont South VIC 3133  
Mob: 0414 344 239

• M A S S A G E •

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.

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

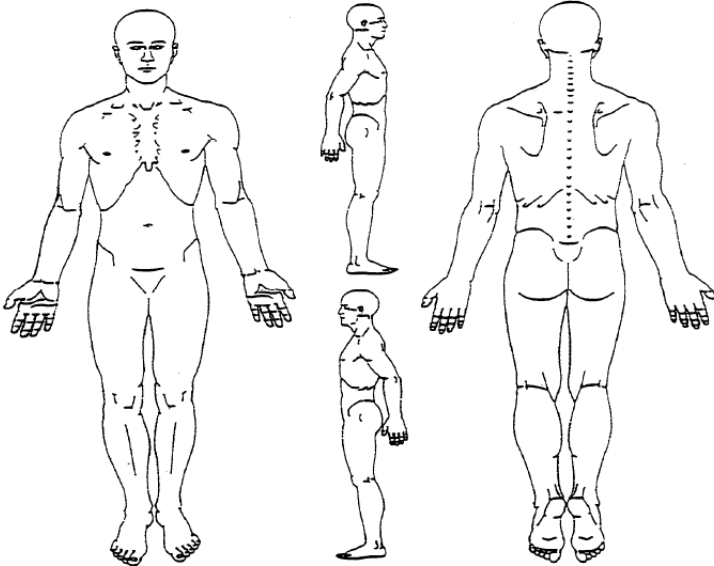
\_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_

Name of favourite charity: \_\_\_\_\_

Signed: \_\_\_\_\_

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 \_\_\_\_\_