Maris Sage
Massage & Reflexology
Remedial ‖ Relaxation ‖ Deep Tissue ‖ Pregnancy ‖ Reflexology

2a/13 Bridge Street, Epping
02 88 196 726
www.MarisSage.com.au
/marisSageRM /+marisSage

Medical History & Consent form

Full Name _____ **Date of birth** _____

Address_____

Suburb _____ **Post Code** _____

E-mail _____ **Phone No.**_____

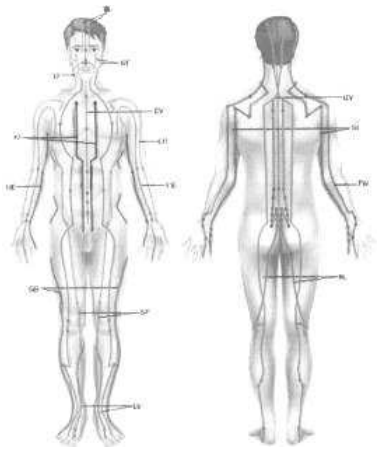
Emergency contact _____ **Contact No.** _____

Occupation _____ **Health Fund** _____

How did you find us? ☐ Signage ☐ Podiatrist ☐ Facebook ☐ Internet ☐ Word of Mouth, _____

Happy to receive e-news and promotions: ☐ No, thanks ☐ Yes please!

1. *Main reason for visit*: Areas of pain, symptoms, relaxation:



_____

_____

Since when? _____

Aggravates with _____

Eases with _____

Nature of pain?

☐ Sharp	☐ Dull	☐ Soothing	☐ Numbness/ Tingling
☐ Throbbing	☐ Aching	☐ Stiffness	☐ Cramps

Have you had other treatments?

☐ Medications	☐ Surgery	☐ Physiotherapy	☐ Naturopath/Homepath
☐ Massage	☐ Chiropractor	☐ Acupuncture	☐ None

Currently under care of another health care professional? ☐ No ☐ Yes, _____

2. *Your medical health history*

Do you take any medication? ☐ No ☐ Yes; _____

Any Allergies/Intolerances ☐ No ☐ Yes; _____
(especially metals and nuts)

Any surgery, fractures, hospitalizations, accidents (whiplash) or injuries?

_____

_____

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3. *Contra Indications*

Any condition being treated by a GP or complementary practitioner should be disclosed, as results of treatment or medication could be affected. **Please tick if you have or ever had:**

☐ Heart conditions	☐ Thrombosis/Embolism	☐ Blood clots/ Phlebitis	☐ Circulatory/ Blood condition
☐ Varicose veins	☐ Diabetes 1-2	☐ Bursitis/ Tendonitis	☐ High/Low blood pressure
☐ Neck/spinal injury	☐ (Osteo)Arthritis	☐ Rheumatisms	☐ Osteoporosis
☐ Spondylitis	☐ Kidney condition	☐ Headaches/migraines	☐ Auto Immune condition
☐ Cancer/ Tumor	☐ Epilepsy	☐ Anxiety/ Depression	☐ Any Mental/Psychotic conditions
☐ (Lymph) Oedema	☐ Thyroid conditions	☐ (Adrenal) Fatigue	☐ Contagious/Infections diseases
☐ Plantar fasciitis	☐ Skin condition; Psoriasis, Dermatitis/Eczema, Athlete's Foot, Etc.		

☐ Other _____

_____

Woman's Health ☐ **Are you pregnant?** If so, how many weeks? _____ No. _____

☐ Menstrual pain ☐ Irregular periods ☐ Excessive/No blood loss ☐ PMS ☐ Mood swings

☐ Fertility issues ☐ Menopause symptoms ☐ Other

4. *Life Style*

Stress level **Work** 0 1 2 3 4 5 6 7 8 9 10 **Private:** 0 1 2 3 4 5 6 7 8 9 10

Energy Level ☐ Like a rock ☐ Difficult to get into sleep ☐ Wake up at night ☐ Dream a lot

Exercise/Hobbies? _____ **Frequency**_____ daily/ x a week

What outcome would you like to achieve with your treatment?

_____

5. *Informed Consent*

I declare that it is my choice to consult and receive massage treatment. I am aware of the benefits and risks and give my consent massage therapy. I acknowledge that massage is not a substitute for medical care, medical examination or diagnosis and I understand that there is no implied or stated guarantee of success or effectiveness for sessions. I have disclosed any condition I have and declare that all information supplied in this personal record form is true and complete at this date. I agree, to take it upon myself to keep the massage therapist updated on my health status 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. I understand that the massage therapist is committed to the privacy of its clients and the client - therapist relationship will be held in strict confidence. Information kept on file will not be released to a third party without the express consent of the client or as required by law. *

Signature client: _____ Date: _____

**Minor Policy:* All persons under the age of 18 must have parent/guardian's consent. All persons under the age of 16 are required to have a parent/guardian present in the room during the time of service.

Parent Name: _____ Signature indicating parental consent: _____

THANK YOU ☺

For a Well-balanced life