MASSAGE THERAPY – CONFIDENTIAL HEALTH HISTORY FORM
(Bellarine MST)

Surname: _____ First Name: _____ DOB: _____

Address: _____ P/code: _____

Phone Numbers: (Home) _____ (Work): _____

Mobile: _____ Email: _____

Contact name and emergency telephone number in case of emergency: _____

GP's name: _____ GP's contact details: _____

GP's Address: _____

Your occupation: _____ Health Fund: _____

Main activity at work (computer work, phone, manual labour etc): _____

Why have you come for treatment today: _____

Have you had a massage before (if so, reason)? _____

Medical History Information:

Please tick (✔) all conditions that apply at present. Put a 'P' for past conditions:

___ chronic headaches/migraines	___ constant pain	___ high/low blood pressure
___ significant visual disturbances	___ accident/trauma	___ heart, stroke, circulatory problems
___ sinus problems	___muscle or joint pain	___ cancer/tumours
___ jaw pain/teeth grinding	___ sprains/strains	___ diabetes
___depression	___ scoliosis	___ asthma
___ excessive fatigue	___ arthritis	___ skin problems, rashes, tinea
___ongoing sleep difficulties	___ tendonitis	___ prostate problems
___swelling/oedema	___ allergies	___ endometriosis
___numbness/tingling	___ varicose veins	___ painful menstruation
___infectious disease	___ blood clots	___ pregnant

Surgery/Hospitalised? _____

Accidents: _____ Sleep quality (poor, average, great): _____

Current medications (including herbs, vitamins, ibuprofen, aspirin etc) _____

_____

Any pain? (Please tick): ☐ muscle ☐ joint ☐ head ☐ neck ☐ other (specify) _____

Are you currently having any other treatment? (Acupuncture, chiropractic, naturopathic, physiotherapy etc.) _____

_____

Recreational sporting activities: _____

What movements, or activities, if any, are limited? _____

How did you find out about Bellarine MST? _____

Consent is required to massage each part of the body. Please indicate which areas can be massaged: _____

☐ Back ☐ Buttocks ☐ Legs ☐ Feet ☐ Arms ☐ Hands ☐ Stomach ☐ Chest ☐ Face ☐ Head/Neck

Are you happy to receive material from Bellarine MST about future special promotions and news? _____

I certify that the information given is correct and current to the best of my knowledge. I have disclosed all medical conditions and medications that I am aware of and will inform my therapist of any changes in the future. I understand that it is not the role of the therapist to diagnose injury or illness, nor does the treatment substitute in any way for medical care I am currently undertaking.

Date: _____ **Signature:** _____

Clients Name: _____ **Office Use Only**

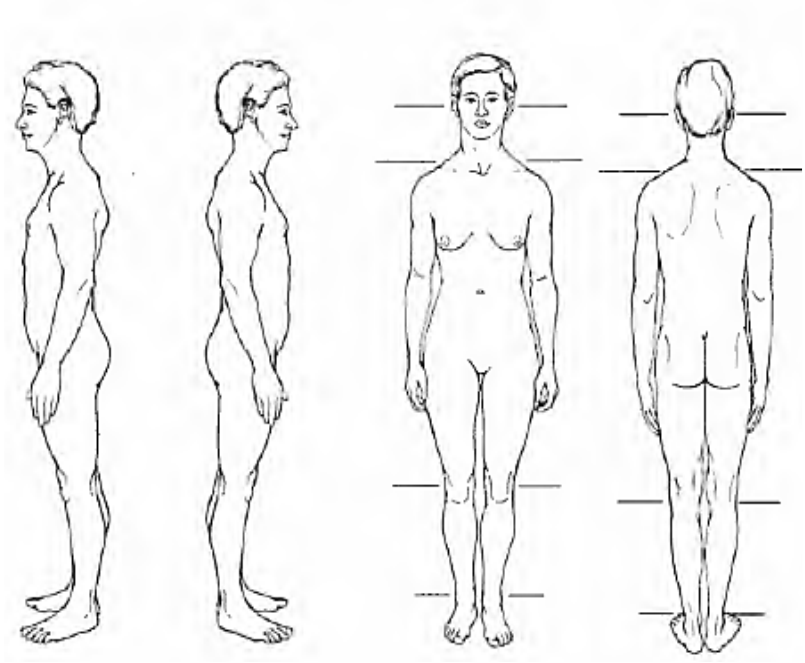
Rx Date:_____ Time:_____ Current Meds: _____

A

S

T

E



Therapist's signature:_____ Recording date & time _____

Symbols for figure drawing:

x	TrP	≈	Adh	≡	Hypertonicity	✱	Swelling
≈	Spasm	Ⓟ	Pain	()	Rotation	↗	Elevation

NOTES

ROM: _____

_____

_____

INJURIES/ACCIDENTS/SURGERY/CHRONIC CONDITIONS/SPECIAL NEEDS: _____

_____

_____

_____

_____

_____

TREATMENT PLAN: _____

_____

_____

_____

_____

_____

_____

_____