Orthopaedic Massage
Client History Form

General Details

Name: _____ Today's Date: _____

Occupation: _____ Date of Birth: _____

Mobile: _____ Work: _____

Home: _____ Email: _____

Male ☐ Female ☐ If female, pregnant? Y ☐ N ☐ If so, current trimester: _____

Sports / Activities: _____

Health Insurance Provider: _____

Emergency Contact Name: _____ Number: _____

Reasons for seeking treatment

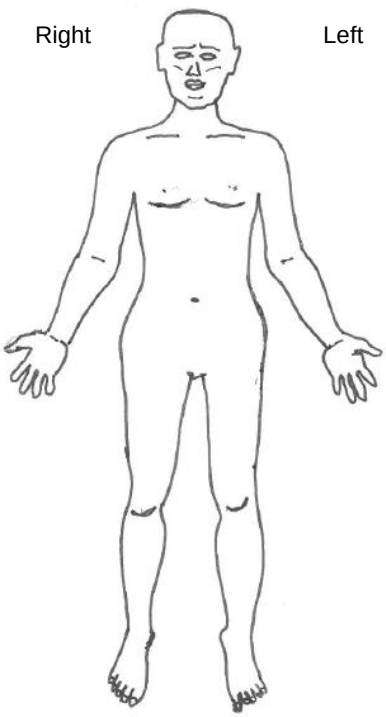
_____

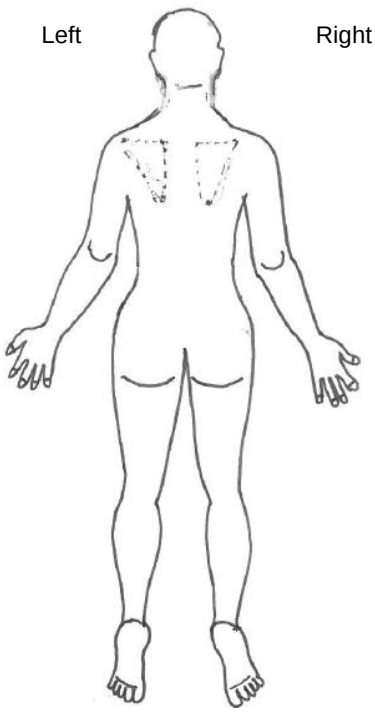
_____

Presenting Symptoms

	Area	Pain Intensity 1-10 (1–None, 10-Extreme)	Pain Type Sharp / Dull / Shooting Constant / Throbbing	When is it worst? Morning? Specific activity?	How long since you had this symptom?
1.					
2.					
3.					
4.					
5.					

Using the above numbering, please locate the items on the diagrams below:





Please turn over

Continued overleaf

Remedial Massage

Medical History

Conditions	Y?	Details
Cardiovascular (heart failure, DVT, etc)	☐	----------
Kidneys (renal failure, etc)	☐	----------
Diabetes (hyper/hypo Glycaemic)	☐	----------
Current infections (cold, flu, STD's, etc)	☐	----------
Digestive (bowel disease, IBS, Crone's etc)	☐	----------
Skin conditions (infectious conditions, etc)	☐	----------
Blood pressure (high /low)	☐	----------
Cancer	☐	----------
Osteoporosis / Arthritis	☐	----------
Accidents / Injuries / Surgeries	☐	----------
Allergies (food, oils / lotions, etc)	☐	----------
Headaches / dizziness	☐	----------
Any other medical conditions	☐	----------
Medications / Supplements	☐	----------

Other Treatments and Outcomes

How did you hear about us?

Please help us by ticking the appropriate box below.

☐ Word of mouth Introduced by: ----------

☐ Flyer / Leaflet ☐ Street Presence ☐ Clinic website ☐ Search Engine

Client Acknowledgement and Consent

I acknowledge that:

- My therapist is not a medical professional and will not provide any diagnosis or medical advice.
- As with any intervention, there is always a small risk that the treatment could have negative effects. I confirm that I have stated all my known medical conditions and answered all questions honestly. I also agree to keep my therapist updated of any changes in my conditions.

I consent to:

- My contact details and treatment notes being stored securely by Ravel Therapies and accessed by its practitioners as required.
- My medical information and treatment notes being released to other medical and health practitioners if I request my therapist to do so.
- My therapist disclosing my personal information, if required to by law.
- Receiving appointment confirmation and reminder emails and text messages, as well as occasional newsletter emails from Ravel Therapies.

I understand and accept the following booking and payment terms:

- Appointments cancelled less than 24 hours from the time of the appointment will incur a charge of 50% of the full consultation fee.
- Consultation fees must be paid in full at the time of the consultation and can be by cash or credit card.

Client Signature: ----------