|  |  |  |  |
| --- | --- | --- | --- |
| **CLIENT HISTORY & HEALTH RECORD** | | | |
| Name: |  | | |
| Address: |  | | |
|  |  | Postcode: | |
| Email: |  | | |
| Phone: | (H) | | (W) |
|  | (M) | | |
| Date of Birth |  | Age: | |
| Health Fund: |  | | |
| Referred by: | How did you find us? | | |
| Occupation: |  | | |
| GP Name: |  | | |
| GP Address: |  | | |
| GP Phone: |  | | |

**Would you like us to add you to our email contact list? Y/N**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Serious Illness: | Detail any serious illness(es) you have had including any residual effects or other problems: | | | | | |
| Hospitalisations & Surgery: | When and what for? | | | | | |
| Accidents: | Have you experienced any physical trauma that required treatment or should have been treated? (include here sporting injury, falls, motor vehicle accidents e.t.c.) - did you experience any residual problems or prolonged side effects? | | | | | |
| Work cover injury? | 🞏 Yes  🞏 No | | | If yes, please provide contact details of your work cover agent: | | |
| Have you had or do you have any of the following conditions?  Allergies: | 🞏 Chest Pain  🞏 Poor Circulation  🞏 Fracture  🞏 DVT Thrombosis/Clots  🞏 Epilepsy  🞏 Migraines  🞏 Headaches  🞏 Pregnant?  Number of weeks?\_\_\_\_ 🞏 Pacemaker  🞏 Scoliosis  🞏 Hearing loss  Specify –  🞏 Nut Allergy 🞏 Latex | | | 🞏 Cancer  🞏 Liver Disease  🞏 Glandular Fever  🞏 Rheumatic Fever  🞏 Teeth grinding  🞏 Osteoporosis  🞏 Diabetes Type 1 or 2  🞏 Endometriosis  🞏 Breastfeeding  🞏 Treatment Port 🞏 Orthotics  🞏 Vision loss | | 🞏Stroke/Blackout/TIA  🞏 Hepatitis A / B / **C** / D  🞏 HIV/AIDS  🞏 Osteoarthritis 🞏 Rheumatoid Arthritis  🞏 Bone Infections  🞏 Asthma  🞏 Breathing difficulties  🞏 Skin Condition  🞏 Recent infection  🞏Vertigo/Balance issues  🞏 Cramping |
| Medication:  (please list and advise for what condition you take it) - Prescribed & Natural (incl vitamins) | 🞏 Blood Thinners (Warfarin or similar) 🞏 Angina Medication 🞏 Epi Pen | | | | | |
| Blood Pressure: | 🞏 Low  🞏 Normal  🞏 High | When was your blood pressure last checked? Record your actual blood pressure (if known) here: | | | | |
| Family Health History | Has anyone in your immediate family suffered from any of the following: | | | | | |
|  | 🞏 Heart Disease  🞏 High Cholesterol  🞏 Diabetes | | | 🞏 Arthritis  🞏 High Blood Pressure  🞏 Neurological disorder | | 🞏 Obesity  🞏 Strokes  🞏 Cancer |
| Recreational activity per week (hobbies, exercise): |  | | | | | |
| Diet: | Rate your diet habits: 🞏 Excellent 🞏 Good 🞏 Fair 🞏 Poor  Would you like to obtain more information about diet and nutrition? **Y/N** | | | | | |
| Sleep: | How many hours do you sleep each night?  Are there any reasons why you don't sleep well? Explain here: | | | | | |
| Dominant hand: | 🞏 Left 🞏 Right | | | | | |
| Emergency Contact: | Name | | | | Phone: | |
| **Complete Section below if the purpose of your visit today is to reduce pain or loss of movement.** | | | | | | |
| Location of Pain? |  | | | | | |
| Onset (when/how?) |  | | | | | |
| Other Symptoms: |  | | | | | |
| Type of Pain? |  | | | | | |
| Referral of Pain: |  | | | | | |
| Aggravated by: |  | | | | | |
| Degree of Pain (0-10): | Onset: | | Now: | | | |
| Irritability: | Easy to Aggravate? | |  | | | |
|  | How long to settle? | |  | | | |
| Offset (Relieved by ): |  | | | | | |
| Past/Current Treatments: | *Physio, Chiro, Osteo, Massage, Myotherapy etc* | | | | | |
| Result of Treatment:    Agreement for Care: | Please read and sign the bottom of this form to confirm that you understand what to expect during this treatment:  City Haven Massage Therapy agrees to provide you with a professional Remedial/Myotherapy treatment tailored to your individual needs with qualified and fully insured therapists.  You as our client, agree that all the information that you have supplied to us in this form is true and correct to the best of your knowledge. Failure to disclose information about your health history may affect the treatment you are given. We cannot be held responsible for any effect our treatment has on an existing condition if you have not disclosed it to us here. Likewise, if you develop a new health condition whilst you are a client of City Haven Massage Therapy, you must advise us of any changes to your health history.  Remedial Massage and Myotherapy is a non -evasive treatment for soft tissue dysfunction. It does not usually have any side-effects, but some people experience post treatment soreness which usually eases in a few days. If you have any concerns about how you feel after your treatment with us, please contact us immediately for assistance.  Underwear is always to be worn during treatments and you will be draped with towels appropriately to respect your privacy.  At any time, during your treatment, if you are uncomfortable, you have the right to speak up and ask your therapist to stop doing a particular technique. You are also able to stop the massage at any point if you wish to.  **Please note that our cancellation policy for future bookings is 24 hours prior to your booked appointment time. If cancelled within 24 hours, a 50% cancellation fee applies. No shows are charged the full fee.**  Your treatment may include the following modalities, please tick any box if you do not wish to receive these techniques during your treatment:  🞏 Dry Needling 🞏 Trigger Point Therapy (using deep pressure on muscles)  🞏 Cupping  🞏 Stretching (including resisted and Muscle Energy Technique)  🞏 Joint mobilisations  I have read the agreement for care and accept these terms and conditions.  **Client Name:**  **Date:**  **Signature:**  🞏 I give permission for my health history and details of my treatments to be shared with other health professionals involved in my care for referral purposes. | | | | | |

Client Consent for Myofascial Dry Needling

Please note that with any procedure where the skin is pierced (for example with Dry Needling) there is a risk of contracting infectious diseases if proper hygiene standards and procedures are not followed.

At City Haven Massage Therapy, we:

* Provide the Dry Needling procedure to deactivate Myofascial Trigger Points - this is not related to acupuncture in any way except the needles are similar.
* Insert needles into the skin to relax restricted muscles.
* use single-use, sterile needles which are disposed of in a sharps’ container immediately after use
* wash our hands before, during and after the treatment
* we cover any cuts to our hands
* Gloves are worn during your treatment by the therapist - Please advise if you are allergic to latex.
* The area to be needled is swabbed using an alcohol wipe to sterilise the area before the needle is inserted.
* In the event that any bleeding occurs we use a sterile cotton swab to clean the area and dispose of that in a sharps’ container - please note bleeding is not common - sometimes a pinprick of blood can appear when the needle is removed. In some cases, a small bruise may result.
* Have a current permit from the Whitehorse City Council/City of Melbourne to provide this service to our clients.

Please advise us:

* via the client form if you have any contagious disease
* if you have any area of broken skin
* if you have an allergy to latex (we may use latex gloves during dry needling treatments)
* at any time if you wish us to cease the treatment
* if you have any additional questions

We follow excellent procedures to ensure both therapist and client safety during the Dry Needling Procedure. This information is available so that you are aware that transmission of contagious diseases during this treatment are possible if professional hygiene standards are not observed.  
I understand the above information and consent to dry needling being used as part of my treatment plan.

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_