west perth osteopathy
whole body health

Pregnancy Massage Confidential Patient Information **Date:** _____

We appreciate your patience in fully completing this confidential questionnaire and your information will be kept strictly private according to clinic policy. The information is necessary in assisting us to provide the best care and will not be divulged to any other person without your prior consent.

Name: _____ D.O. B. _____

Address:_____

Email: _____

Phone: (H) _____ (W) _____ (M) _____

Occupation: _____ G.P. Name & Location: _____

Marital Status: _____ Children: _____

Private Health Fund:_____

Emergency Contact: _____

How did you find out about West Perth Osteopathy?

□ Friend/Relative. Please specify_____

□ Yellow Pages Printed □ Yellow Pages On-Line □ Our Website □ Google

□ Natural Therapy Pages □ Signage □ Australian Osteopathic Association (AOA)

□ Professional (e.g. GP, Podiatrist). Please specify_____

PREGNANCY INFORMATION

Weeks Pregnant?_____ Due date? _____

Obstetrician / Midwife: _____

Hospital: _____

Birth Plan: _____

_____

Previous Pregnancy/s: _____

Length of gestation: _____

MEDICAL HISTORY – *Please indicate any problems below*

	Y	*N*		*Y*	*N*
Heart / Circulation Problems			Oedema / Swelling		
Blood Clots / Thrombophlebitis			Sciatica / Gluteal Pain		
Osteoporosis / Arthritis			Lower Back Pain		
Spinal Disorders			Hip Pain		
Headaches / Migraines			Symphysis Pubis Separation		
Pain / Numbness / Tingling			Abdominal Muscle Separation		
Insomnia			Diabetes /Gestational		
Fatigue / Chronic Fatigue			Preterm Labour		

Nausea			Preeclampsia		
Depression			Uterine Bleeding		
Bladder Infection			Previous Caesarean		
Leg Cramps / Restless Legs			Previous Miscarriage		
High Blood Pressure			Placenta Insufficiency		
Low Blood Pressure			IVF Treatment		
Varicose Veins			Twins or More		
Carpal Tunnel			Other		

Describe any surgery or hospitalisations you have had during your life time?_____

_____

What accidents have you had in your lifetime? (e.g. car, work or sporting related)?_____

_____

Do you have any skin sensitivities or allergies? □ Y □ N If yes, please specify: _____

_____

Are you taking any medications/natural supplements? □ Y □ N If yes, please specify: _____

_____

Exercise/Hobbies: _____

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INFORMED CONSENT TO PREGNANCY MASSAGE

I hereby request and consent to the performance of Massage Therapy on me by Yuli Rai and/or any other Massage Therapist working in this clinic authorized by Ray Power.

I have had the opportunity to discuss the nature and purpose of Massage Therapy with the Therapist.

I understand that results are not guaranteed.

I understand that the massage I receive is provided for the purpose of relaxation and/or relief of muscular tension, and that if I experience any concerning discomfort during the session, I will immediately inform the Therapist.

I understand, and am informed, that as in the practice of medicine, in the practice of Massage Therapy there are some risks to treatment, including, but not limited to, muscle pain, mild headaches, nausea, and/or dizziness. It is advisable to avoid eating large meals immediately prior to massage, and to drink water soon after. It is advisable to consult with your doctor, obstetrician, midwife or other physician before receiving Massage during pregnancy.

I do not expect the Therapist to be able to anticipate and explain all risks and complications and I wish to rely on the Therapist to exercise judgment during the course of treatment, which the Therapist feels at the time, based upon the facts then known, is in my best interests.

I understand that Massage Therapy should not be construed as a substitute for medical examination, diagnosis, or treatment.

I have read the above, and I have also had the opportunity to ask questions about its content.

I intend this consent form to cover the entire course of treatment for my present condition, and for other future condition(s) for which I seek treatment. I understand that I can withdraw my consent at any time.

I _____ understand that the time I book with my practitioner/s
Patient's Name

is specifically reserved for me. Therefore **I must give 24 hours' notice to change/cancel appointments;**

otherwise a cancellation fee will be applied.

This enables us to offer your appointment to other patients who require treatment.

You will receive a courtesy reminder the day prior to your appointments.

☐ I do **not** wish to receive the (quarterly) Clinic Newsletter or any other clinic news/articles of interest via email.

- **Yuli Rai**
  Dip. Remedial Massage

_____
Patient's Signature

_____
Date