west perth osteopathy
*whole body health*

**Massage Therapy 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:________________________________________________________

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_____________________________

**Personal Health Information**

What is your reason for attending the clinic?_____________________________________

________________________________________________________________

How have these problems interfered with your normal activities or work?_______________

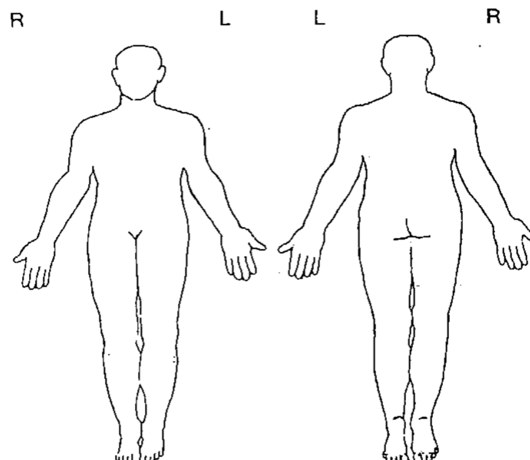
Have you had other treatment for these problems? □Y □N, If so from Whom?_______________

Last seen & result of treatment?__________________________________________

Previous massage/s? ____________________________________________________

Are you under the care of any other health practitioners?__________________________

*Please indicate where your present symptoms are on the diagram below-*



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Are you Pregnant □Yes □No, Weeks Pregnant? _______________ Trying to fall Pregnant? □Yes □No

**MEDICAL HISTORY** – *Please indicate any problems below*

| | *Y* | *N* | | *Y* | *N* |
|---|---|---|---|---|---|
| Abdominal / Digestive Issues | | | Allergies | | |
| Asthma / Lung Condition | | | Blood Clots / Thrombophlebitis | | |
| Burns or Bruising | | | Cancer / Tumours | | |
| Depression | | | Diabetes | | |
| DVT (Deep Vein Thrombosis) | | | Eczema / Psoriasis | | |
| Epilepsy | | | Fatigue / Chronic Fatigue | | |
| Foot or Ankle Swelling / Oedema / Inflammation | | | Foot Disease – e.g. plantar warts, athlete's foot | | |
| Foot Disorders – e.g. bunion, corns, calluses, heel spurs, plantar fasciitis, Morton's neuroma | | | Fractures | | |
| | | | Hearing Problems | | |
| Headaches / Migraines | | | Hernias | | |
| Heart / Circulation Problems | | | Infectious Disease | | |
| High / Low Blood Pressure | | | IVF Treatment | | |
| Insomnia | | | Lymph Node Removal | | |
| Kidney Ailments | | | Muscle / Bone Injuries | | |
| Lymphoedema | | | Nausea | | |
| Muscle / Joint Pain, Strain or Sprain | | | Pacemaker | | |
| Osteoporosis / Arthritis | | | Seizures | | |
| Pain / Numbness / Tingling | | | Spinal Disorders | | |
| Skin Rash / Athlete's Foot / Tinea | | | TMJ (Temporomandibular Joint) Syndrome | | |
| Stroke | | | Varicose Veins | | |
| Unstable Pregnancy | | | Vision Problems / Contact Lenses | | |

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 MASSAGE THERAPY**

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 as authorised 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, because Massage should not be performed under certain circumstances, I must update the practitioner to any changes to my health as soon as I become aware of them, and agree to release the Therapist from my liability if I fail to do so.

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 and joint soreness, muscle strains, mild headaches, and light headedness.

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**