Client Consent and Information Form

SECTION 1 - PERSONAL INFORMATION	
TITLE:	**PHONE:**
FIRST NAME:	**WORK PHONE:**
PREFERRED NAME:	**MOBILE:**
LAST NAME:	**EMAIL:**
GENDER:	**HOME ADDRESS**
DATE OF BIRTH:	**STREET:**
NAME OF GP:	**POST CODE:**
MEDICAL PRACTICE:	**ETHNICITY:**
OCCUPATION:	**EMPLOYER ADDRESS:**
EMPLOYER NAME:	

WHY DID YOU CHOOSE US : ☐ Recommended Clinic	☐ Recommended Who: ……	☐ Previous treated ☐ Doctors Referral	☐Location ☐ Other:……..
WHO REFERRED YOU? ☐ GP	☐ Specialist ☐ Physiotherapist	☐ Friend/Family ☐Other ……	

Please advise if you would not like to be reminded of your appointment via text messaging: ☐ NO

Please advise if you would prefer not to receive any e-mail information about our services: ☐ NO

SECTION 2 - GENERAL HEALTH QUESTIONNAIRE:			
☐ Pregnant ☐ Physical disability ☐ Diabetes	☐ Heart problems ☐ Skin condition ☐ Cancer ☐ Pacemaker	☐ Hearing/sight impaired ☐ Hep C/HIV ☐ Other (Specify) …… ☐ Circulation/Vascular Problem	☐ Asthma/Respiratory/ Breathing ☐ Artificial Implants ☐ Allergy (Specify) ……

HAVE YOU USED OR ARE USING STEROIDS ☐ **ANTICOAGULANTS** ☐ **OTHER MEDICATIONS:**

SECTION 3 – CONSENTS

I hereby give my consent to Hands On Massage Practitioners to treat me. I understand I have the right to decline any and all treatment offered to me at the time. I also understand the massage practitioner may discuss my treatment with other practitioners at the Hands On Clinic, in line with the clinic's multidisciplinary approach.

AGREEMENT TO PAY:

I understand that I am liable to pay for :

- Any private treatment or copayment charges for ACC treatments
- **If I fail to attend my appointment or cancel within 24 hours of the scheduled time, I may be charged a cancellation fee of up to the full treatment charge.**
- If I fail to pay for my appointment at the time of treatment I may be charged an account administration fee.
- Any treatment that is declined by ACC or other funder
- The costs of materials such as orthotics, materials, products etc

I understand that if this service requires engaging a Debt Recovery Service to recover my debt, I will be liable for any recovery fees.

CONSENT TO RELEASE INFORMATION TO A 3rd PARTY

I consent to the disclosure of my records to any person/organisation necessary for the effective management of my condition.
I consent to a discharge/update report being sent to my doctor or medical centre.

I have read and understand the information above.

SIGNED: **DATED:**

(If under 16 must be signed by parent/guardian)

HANDS ON HEALTH HISTORY FORM

Name: **Date of Birth:**

Type and frequency of exercise

Previous massages?

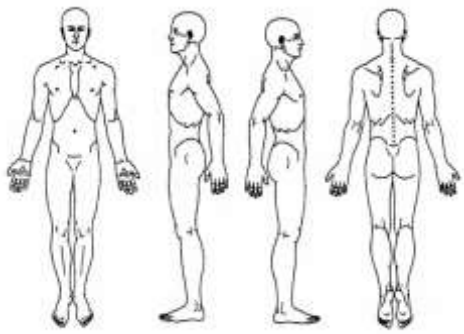
What is your current problem or symptom?

Is this getting progressively worse?

Pain Scale: 1 2 3 4 5 6 7 8 9 10 Constant/Comes and goes

If you have any of the following conditions, please tick where appropriate:

	General Health		Head & Neck		Chest & Abdomen
	Allergies		Pain in Head(where)		Heart Problems/Angina
	Arthritis		Dizziness/Fainting		Shortness of Breath
	Diabetes		Jaw Clenching/Teeth Grinding		Asthma/ Respiratory Problems
	Psoriasis/Eczema/ Sensitive skin		History of Head or Neck injury		Abdominal Pain
	Fungal Infections		Stiff or painful neck movement		Constipation/Diarrhoea
	Bursitis		**Spinal Problems**		PMT/ Heavy/Painful Menstruation
	Infection/Influenza/Cold		Upper/Mid/Lower Back		**Medication/Supplements - please list**
	HIV/Hepatitis		Disc Problem		
	Sinusitis		Pain/Stiffness (where)_____		
	Seizures/Convulsions		Worse when sitting/lying?		
	High/Low Blood Pressure		Worse when working?		
	Poor Circulation in hands/feet		Previous x-rays?		
	Osteoporosis		**Hips and Legs/Feet**		**Please circle areas of pain/discomfort**
	Bruise easily	L/R	Sciatica		
	Are you Pregnant?# wks____	L/R	Hip/Knee Pain or Stiffness		
	Shoulders and Arms	L/R	Hip/Knee replacement		
L/R	Pain (Front/Back)	L/R	Leg cramps		
L/R	Dislocations(When)_____	L/R	Varicose Veins		
L/R	Weakness of Grip	L/R	Thrombosis/Clots History		
L/R	OOS/RSI	L/R	Numbness/Pins & Needles		
L/R	Carpal Tunnel Syndrome	L/R	History of Injury		
L/R	Numbness/Pins & Needles	L/R	Shin Splints/Gout		



Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the massage practitioner updated as to any changes in my medical profile and understand that there should be no liability on the practitioner's part should I fail to do so.

Signature:_____Date:_____