



KARRINYUP WELLNESS CENTRE

Chiropractic • Massage • Naturopathy

Massage Client Information and Consultation Form

Welcome to the Karrinyup Wellness Centre

Title: (Please circle) Mr/Mrs/Ms/Miss/Dr

Full Name: _____ Date of Birth: _____

Address: _____
Street Suburb Post Code

Phone: Home _____ Work _____ Mobile _____

Occupation: _____ Email Address: _____

Are you in a health fund? Yes No

Name of Fund: _____ Your number (eg 01 or 02) _____

Emergency Contact Name & Phone no. _____

Reason for Appointment: _____

Have you had a therapy massage before? YES / NO If "YES", how long ago? _____

What techniques have you received? _____

What benefits have you experienced from massage? _____

Are you currently or have you in the past received any other forms of bodywork? _____

List current medications: _____

List any allergies: _____

Place a check mark next to any of the following that apply:

- | | |
|---|--|
| _____ Frequent Headaches | _____ Any Skin rash or condition |
| _____ Arthritis | _____ Diabetes |
| _____ Varicose Veins | _____ Pregnant (Due Date: _____) |
| _____ Osteoporosis | _____ High Blood Pressure |
| _____ Fibromyalgia / Chronic Fatigue | _____ Any Contagious Disease / Illness |
| _____ Chronic Back / Neck Pain | _____ Allergies (Skin, Drug, Other) |
| _____ Blood Clots / Phlebitis | _____ Scoliosis |
| _____ Inflammation / Swelling | _____ Injuries within past 12 months |
| _____ Cardiac or Circulatory Problems | _____ Surgeries within past 12 months |
| _____ Cancer (currently or within past 12 months) | |

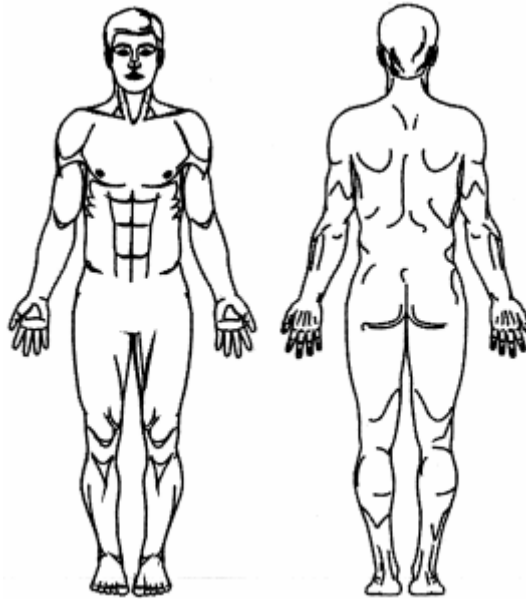
Do you have any other medical conditions? _____

Would you like light, medium, or deep pressure during your massage? _____

What Outcome do you expect from this massage/bodywork session? _____

Briefly outline what your health goals are? _____

On this diagram please circle the areas of your body that you feel needs the most attention and place an "X" over the areas that you wish to avoid.



Please indicate on a scale of 1-10 (1 being minimal and 10 being extreme)

Stress Levels	/10	Pain	/10	Anxiety	/10
Sleep	/10	Energy	/10		

Please read the following information and sign where indicated:

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. There are certain medical conditions in which receiving a massage may not be appropriate. In those cases a referral from a physician may be required prior to services being provided. Massage/bodywork is not a substitute for medical attention received by a medical specialist. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure/strokes may be adjusted. In addition, if I am uncomfortable for any reason, I may ask that the session be stopped immediately.

Draping will always be used during massage/bodywork sessions. No breast massage shall be done without written consent of the client and therapist. Any illicit or sexually suggestive remarks or advances made by me (the client) will result in the immediate termination of the session.

Please note late cancellation or missed massage appointments will incur the full fee.

Client Signature: _____

Date: _____