Massage

Catalyst Health and Wellness Group

602 Barkly Street, Ballarat, VIC 3350

CONFIDENTIAL PATIENT INFORMATION

Welcome to our practice! Please complete all questions and PRINT clearly. Date: _____

Surname:	First Name:	Preferred Name:
Address:	Town:	Post Code:
Home Ph:	Work Ph:	Mobile Ph:
Birth Date: / /	Email:	
Occupation:	Employed by:	
Type of work: ☐ Sitting ☐ Computer ☐ Standing ☐ Driving ☐ Lifting ☐ Other_____		
Emergency Contact Name and Number:		
Children's name & ages:		
Method of payment for first visit: ☐ Cash ☐ Cheque ☐ Credit Card		
Do you have private health insurance that covers you for remedial massage therapy? Yes / No If yes, which fund _____		
Whom may we thank for referring you to our practice?		

Please list your chief complaints in order of severity,

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Where is the main problem?_____

Is the pain ☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing ☐ Like pins & needles

Does the pain spread? ☐ Yes ☐ No If yes, to where?_____

Do you have numbness? ☐ Yes ☐ No If yes, where?_____

Is there pain when you cough or sneeze? ☐ Yes ☐ No If yes, where?_____

Is there pain when you sit or stand? ☐ Yes ☐ No If yes, where?_____

Is the pain getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes & goes

Do you have headaches? ☐ Yes ☐ No If yes, circle all that apply:

Tension Throbbing Sinus Migraine Other:_____

Indicate any function below that aggravates or are aggravated by your condition *(please circle all that apply):*

Walking Steep climbing Driving Working Recreation Bowel movements Digestion

Breathing Sinuses Sleeping If female, menstruation Other_____

Have you ever experienced Varicose Veins? ☐ Yes ☐ No (Contraindication to having Massage on area)

Does you father, mother, sister, brother or children have similar problems? ☐ Yes ☐ No If yes, who? _____

Any **Allergies**:_____

Is there any chance that you are pregnant? ☐ Yes ☐ No If Yes, how many weeks pregnant? _____ weeks

Date of onset of last menstrual period (if applicable): _____

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If yes, what kind? _____

Previous massage care *(leave blank if no previous massage)*

Previous massage therapist's name:_____ Approximate date of last visit: _____

Type of care: Symptom based / Non-symptom based *(wellness or maintenance)*

Techniques used: Relaxation / Deep tissue / Dry needling / Lymphatic / Remedial / Other _____

Imaging History			
☐ Previous x-rays	Approx. Date: ___/___/___	Area:	Do you have a copy of report?
☐ Previous MRIs	Approx. Date: ___/___/___	Area:	Do you have a copy of report?
☐ Previous CT scans	Approx. Date: ___/___/___	Area:	Do you have a copy of report?
☐ Other imaging	Approx. Date: ___/___/___	Area:	Do you have a copy of report?

Please list any operations you have had:

1. _____ 2. _____ 3. _____

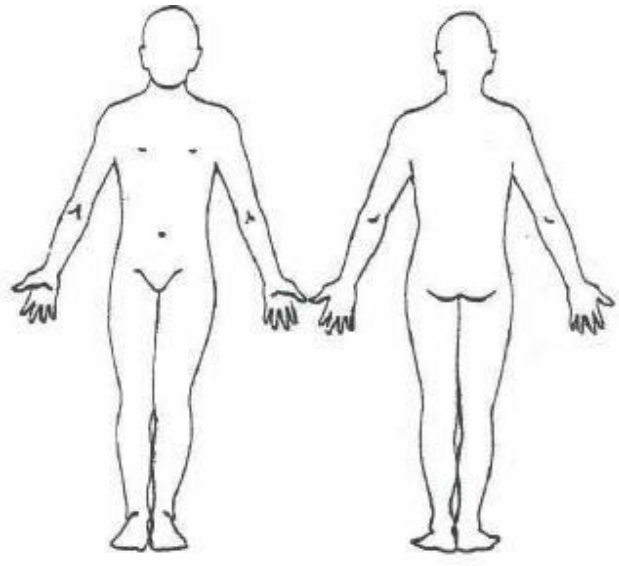
Please list any serious injuries, illnesses or accidents you have had: (including as a child)

1. _____ 2. _____ 3. _____

General Practitioner's Details	
Name:	Clinic name:
Address:	

Please mark areas of complaint on the chart below & indicate the type of pain using the following legend:

Numbness	Pins & needles	Burning	Aching	Stabbing
_____	OOOOOOOOO	XXXXXX	********	///////////////
_____	OOOOOOOOO	XXXXXX	********	///////////////



Pain Chart:

Neck/Shoulder/Arm Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 (no pain) (severe pain) 10

Mid Back Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 (no pain) (severe pain) 10

Low Back and Leg Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 (no pain) (severe pain) 10

When the pain is at its worst, how does it feel? _____

What exercise do you currently do and how often do you do it? _____

_____

_____

Do you drink alcohol? ☐ Yes ☐ No

If so how much? _____

Do you drink caffeinated drinks? ☐ Yes ☐ No

If so how many and what type? _____

How many Cups of water do you drink per day?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ More _____

Legs and Feet

1. Do you experience pain in your legs or feet? Yes / No
2. Do you think you have mechanical foot problems? Yes / No
3. Are you interested in general foot care? Yes / No

Emotional Stress

Please mark the line with an 'x' Is

your work stress

LOW _____ HIGH

Is your relationship stress

LOW _____ HIGH

Is your family stress

LOW _____ HIGH

Is your financial stress

LOW _____ HIGH

Do you consider yourself an **emotional, stressful, anxious or depressed** person? *Please circle*

Have there been moments in your life where you have felt an inability to cope? ☐ Yes ☐ No

Current Medications		
Medication Name	**Reason for taking**	**Dosage**

PATIENT SIGNATURE: _____ Date: / /

PRACTITIONER SIGNATURE: _____ Date: / /

CONSENT TO REMEDIAL MASSAGE THERAPY

Remedial Massage Therapy is recognised as being an effective and safe method of treatment for many conditions.

However, you must recognise that there is always some risk associated with any treatment. Below is a summary of potential risks associated with the therapies used within this practice, together with strategies that you can use to minimise the possible risk. The best way to minimise the chance of risk occurring is to answer all of the questions, about your health, fully and honestly. All remedial massage therapists working at Catalyst Massage will explain the treatment to you before they commence, but you must ask if you require further explanation or have specific questions.

Outline of Possible Risk	**Therapy**	**Strategies to Minimise the Possible Risk**
Pain	• Massage • Dry Needing	Tell your therapist if you are sensitive to stimulation, and if you become uncomfortable or experience pain during treatment
Bruising	• Massage • Dry Needing	Tell the therapist if you bruise easily or have a bleeding disorder
Relaxed / Sleepy	• Massage	It is common to feel relaxed or sleepy after treatment, so avoid getting up quickly from the treatment table and give yourself time to adjust Remedial Massage Therapy is recognised as being an effective and safe method of care for many conditions. after treatment before driving or using stairs. Avoid driving immediately after treatment if you feel sleepy. Keep well hydrated with water.
Fainting	• Massage • Dry Needing	Do not skip a meal before treatment. Get up slowly after the treatment. Keep well hydrated with water.
Aggravation of your Condition	Any Therapy	It is possible that you condition could be aggravated. This is uncommon, but it can occur

FURTHER INFORMATION REGARDING DRY NEEDLING TREATMENT (DNT)

- Dry Needling Treatment (DNT) is recognised as being an effective and safe method of treatment for myofascial trigger points (Trigger points).
- However, you must recognise that there is always some risk associated with any treatment. Serious side effects associated with DNT are rare, with an incidence of 1 in 10,000 treatments.
- The possible risks and adverse reactions to DNT include, but are not limited to, temporary pain, nerve injuries, bleeding (3%), bruising, swelling, infection and nerve shock, nausea, drowsiness, increased symptoms, fainting and local skin inflammation.
- Other more serious but rare events include injury to the heart or lung (cardiac tamponade and pneumothorax), deep venous thrombosis (DVT), blood vessel occlusion, brain stem injury, septic arthritis and abscess. We have
- implemented the following procedures to minimise the above risks and adverse reactions:
  - Full and complete case history and examination ○ Your therapist will always take a thorough case history that covers your presenting complaint, past history and medical history. We will also carry out a thorough examination to determine the nature of your complaint as well as reduce any risk factors. • DNT training ○ Your therapist is qualified to provide patients with DNT and has satisfied the requirements of the training program they undertook in order to provide this treatment. • DNT safety protocol ○ If DNT is required, prior verbal permission will be obtained ○ All DNT needles are single use only, sterile and of the highest quality possible.
  - ○ All therapists will ensure that they meet strict hygiene requirements before applying DNT.

PRIVACY / MODESTY

We respect your right to privacy and to protect your modesty during treatment. As part of the examination and treatment process, you may be required to remove your clothing. This is in order for your therapist to determine the nature of your symptoms and be able to effectively treat you. We will always endeavour to minimise the amount of clothing you will be asked to remove and will cover those areas that are not being treated directly. If you would like to use a gown during your treatment, please inform your therapist. If you have any concerns about this aspect of your treatment, please do not hesitate to discuss with your therapist.

TREATMENT OF CHILDREN

It is the policy of this clinic that any patient under the age of 18 must have their parent or legal guardian present during the patient's initial consultation and all subsequent appointments.

CONSENT

I hereby request and consent to the performance of treatment on me by my therapist. I do not expect, unless asked, the therapist to be able to anticipate and explain all of the risks and complications, and I wish to rely on the practitioner to exercise judgement during the course of the treatment, which they feel at the time, based upon the facts then known, is in my best interests.

PTO

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

Signing this form does not remove my rights to withdraw from any treatment option my therapist may offer now or in the future.

I understand that the aforementioned are possible significant risks and complications specific to my individual circumstances that may be bearing upon my decision to proceed with the proposed treatment.
The therapist has explained the treatment options to me and will discuss any further proposed changes to the treatment with me during the treatment.
The therapist has explained the associated risk and possible side effects of this treatment and any potential risks or outcomes if the treatment is changed.
The therapist has explained that I have the right to refuse treatment or changes to the treatment and that they or I have the right to stop the massage at any time.
I understand that I have the right to ask for further information on treatments that include breast, buttock or groin areas and refuse treatment of these areas at any time. I may be requested to complete a further consent form for these areas to be treated.

I have the following points of concern and have advised the therapist prior to treatment
.....
.....
.....
.....

I understand that it may be necessary for my therapist to discuss my condition and / or treatment with my general practitioner, chiropractor, physiotherapist or referring practitioner. I understand that my therapist will inform me, prior to any discussions with third parties, if this is the case and that I have the right to request a copy of the privacy policy from this therapist.

Missed Appointments

Catalyst Massage has a 50% cancellation fee that will be applied to missed or excessively late appointments. An appointment cancellation fee may not be charged if the clinic has been notified of the cancellation with at least 24 hours notice prior to the original appointment.

I hereby give my consent to this treatment.

……..
Patient's Signature
(Parent or Guardian to also sign if patient is under 18)

…….
Remedial Massage Therapist's Signature

……..
Patient's Name (printed)
(printed)

…….
Remedial Massage Therapist's Name
(printed)

……..
Date

…….
Date