

Welcome to



Institute of
Sports and Spines

Remedial Massage New Patient Information Form

Title: _____ Name: _____ Middle Initial/s: _____ Surname: _____

Home Address: _____ Suburb: _____ Postcode: _____

D.O.B. _____ Phone: Home: _____ Work: _____

E-mail address: _____

If you are a **current patient** of Institute of Sports and Spines, please skip to **'Reason for Visit'** section below.

Private Health Fund: _____ Memb No. _____ No. on Card _____

Medical Practitioner's (GP) Name: _____ Phone: _____

Next of Kin/Emergency Contact: _____ Relationship: _____ Ph: _____

Name of person who referred you to us or how did you hear about us? _____

What is your occupation or major daily activity? _____

Hobbies / Sports / Specific Health interests: _____

Do you exercise regularly? If so please give details: _____

I would like to receive marketing emails from Institute of Sports and Spines Yes No

REASON FOR VISIT: _____

Please indicate the approximate areas on the diagrams:

Pain XXXX Stiffness ++++++

Pins & Needles \\\\\\\\\\\\\\\\\\\ Numbness 000000

Please indicate the level of pain you are suffering.

0 _____ 10
No pain Moderate Pain Worst Pain

How would you describe the pain/problem?

When and how did the problem start? _____

Does anything aggravate the pain? Lying Standing Sitting Movement Other _____

Does anything relieve the condition? Yes No If yes please explain _____

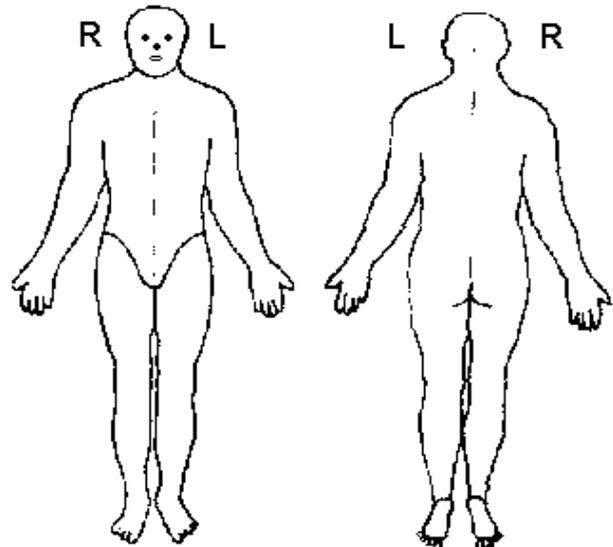
What activities cause you pain? What do you avoid because of the potential for pain or restriction? What would be good benchmarks to use to assess progress? _____

What treatment have you had for this condition? _____

Have you taken any form of pain killer prior to this treatment? _____

What goals do you hope to achieve with treatment, what are your expectations?

Have you had any xrays or scans prior to your visit? If so, where? _____



Have you had or do you have existing ailments (If so please give details):-

- Fractures/ Dislocations _____
- Major Accident's _____
- Medical Tests / Blood tests _____
- Surgery _____
- X-rays _____
- Medication _____
- Illness / Infection / fever _____
- Smoking / Drinking _____
- Recent GP visit _____
- Other _____

Have you previously, or do you currently experience any of the following conditions?

- Are you pregnant
- Allergies
- Stroke / DVT
- Blood/Heart Disorders
- Migraines
- Cancer
- Epilepsy
- Auto-Immune Disorder
- Bowel/Bladder
- Digestive
- Sexual Dysfunction
- Thyroid Disorders
- Stress
- Anxiety
- Emotional Disorders
- Insomnia

Please give details: _____

Do you have a family history of Stroke Heart/ Blood disorders Cancer / Malignancy Diabetes Other Please List _____

Massage Consent To Treatment – Patient Information

Remedial Massage Therapy is a therapeutic approach that uses manual techniques to assess, treat, and manage musculoskeletal pain, injury, and dysfunction. The aim is to: reduce pain and muscle tension, improve mobility and flexibility, support rehabilitation and recovery.

Treatment may involve: deep tissue massage, trigger point therapy, myofascial release, joint mobilisations, stretching and assisted movements, use of oils, balms, or creams. Professional draping will be used at all times, and only the area being treated will be exposed.

Remedial Massage therapy offers a variety of potential benefits including: relief of muscle tension and pain, increased range of motion, improved blood flow and tissue healing and enhanced relaxation and wellbeing.

While generally safe, remedial massage may involve the following risks: temporary muscle soreness, tenderness, or stiffness (commonly within 24–48 hours), mild bruising or redness at the treatment site, exacerbation of existing symptoms in rare cases, temporary dizziness, light-headedness, or fatigue, reactions to massage oils, creams, or lotions (skin irritation or allergy), aggravation of certain medical conditions if not disclosed beforehand.

Rare but possible risks: nerve irritation or inflammation, strain of muscles, tendons, or ligaments if excessive pressure is used.

Massage may not be suitable if you have acute injuries, fractures, or open wounds, fever, infection, or contagious illness, deep vein thrombosis, clotting disorders, or recent surgery, certain cardiovascular or neurological conditions, pregnancy (without prior approval). In these cases, your therapist may require written medical clearance before proceeding.

The client is responsible for:

- Disclose all relevant medical history, medications, allergies, and current symptoms,
- Communicate any discomfort, unusual sensations, or concerns during treatment so adjustments can be made,
- Understand that remedial massage is not a substitute for medical diagnosis or treatment.

I understand the nature, benefits, and potential risks of remedial massage therapy as explained above.

I have had the opportunity to ask questions and all have been answered to my satisfaction. I consent to receive remedial massage therapy and accept the possible risks involved. I understand I may withdraw consent at any time.

Print Full Name: _____ **Sign Here**(or Legal Guardian): _____ Date: / /20

In our digital form, Entering your name in the box above and returning the forms to us acknowledges that you have read the form and consent to assessment and treatment.