VOICERELEASE MASSAGE - CONFIDENTIAL HEALTH HISTORY FORM

Surname:	First Name:
Address:	Phone No. :
Email:	Contact name & telephone number in case of an emergency:
Your occupation:	

Why have you come for treatment today?

_____

Have you had a VRMassage before?

_____

Medical History Information: Please cross X all conditions that apply now. Put a 'P' for past conditions:

___ chronic headaches/migraines	___ cancer/ tumours	___ scoliosis
___ sinus problems	___ accident/trauma	___ arthritis
___ jaw pain/teeth grinding	___ muscle or joint pain	___ tendonitis
___ constant pain	___ sprains/strains	___ allergies
___ high/low blood pressure	___ varicose veins	___ blood clot
___ heart, stroke, circulatory problems	___ prostate problems	___ diabetes
___ significant visual disturbances	___ infectious disease	___ asthma
___ skin problems, rashes, tinea	___ excessive fatigue	___ cancer
___ ongoing sleep difficulties	___ painful menstruation	___ endometriosis
___ swelling/ oedema	___ numbness/tingling	___ epilepsy
___ bruxism / teeth grinding	___ pacemaker	___ depression
___ left OR ___ right handed	___ vocal problems	
___ ongoing sleep difficulties		
other:		

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Any problems with your back ? Slipped disc or broken bones?

_____

Surgery or Hospitalised?_____

Accidents: _____

Sleep quality (poor, average, great): _____

Do you have vocal problems right now? _____

Current Medications: (including herbs, vitamins, ibuprofen, aspirin etc.):

_____

Any pain?: (please tick) ☐ muscle ☐ joint ☐ head ☐ neck ☐ other (specify)

_____

Are you currently having any other treatment? (acupuncture, chiropractic, naturopathic, physiotherapy
etc.)_____
Recreational/sporting activities:

_____

What movements, or activities, if any, are limited?

_____

How did you find out about VRMassage?

_____

Do you have any implants or wear a brace? _____

Consent is required to massage each part of the body. Please indicate which areas can be massaged:

Back ☐ Buttocks ☐ Legs ☐ Feet ☐ Arms ☐ Hands ☐ Stomach ☐ Chest ☐ Face ☐ Head / neck ☐

Are you happy to receive material from me about future specials and promotions?_____

I certify that the information given is correct, current to the best of my knowledge. I have disclosed all medical conditions and medications that I am aware of and will inform my therapist of any changes in the future. I understand that it is not the role of the massage therapist to diagnose injury or illness, nor does the treatment substitute in any way for personal medical care I am currently undertaking.

Date:_____ Signature: _____