NSW SCHOOL of MASSAGE

Initial Visit Case History/Treatment Form

Date & Time: ☐ 1 hour ☐ 1 ½ hours ☐ 2 hours Have you had massage before? ☐ Yes ☐ No

Massage Treatment Log # _____ Type:

Client's Personal Information

Full Name

Contact Phone ☐ Male ☐ Female

Date of Birth Occupation

Email

Medical History / Contraindications – *if you've answered YES, please provide specific details in space below*

Medications	☐ NO	☐ YES	
Allergies	☐ NO	☐ YES	
Pregnant	☐ NO	☐ YES -	How many weeks?
Physically active	☐ NO	☐ YES	
Exercise	☐ NO	☐ YES -	Type: Frequency:

Injuries ☐ NO ☐ YES - *provide details of WHERE & WHEN in space below*

☐ Broken Bones / Fractures ☐ Inflammation ☐ Bruising ☐ Recent Surgery

☐ Sprains/Strains ☐ Dislocations ☐ Burns ☐ Other

Details:

Medical Conditions ☐ NO ☐ YES - *provide details of WHERE & WHEN in space below*

☐ Herniated Disc / Bulging Disc	☐ Skin Conditions	☐ Cancer	☐ Asthma
☐ Numbness / Tingling	☐ Open Sores	☐ Sleep Disorders	☐ Arthritis
☐ Osteoporosis	☐ Contagious Conditions	☐ Epilepsy	☐ High / Low Blood Pressure
☐ Scoliosis	☐ Infection	☐ Lymphoedema	☐ Varicose Veins
☐ Heart Conditions	☐ Fever	☐ Vertigo / Dizziness	☐ Recent Illness
☐ Blood Clots / DVT	☐ Headaches / Migraines	☐ Stress / Anxiety	☐ Other
☐ Bleeding Disorders	☐ Diabetes: ☐ Type I ☐ Type II		

Details:

Reason for Massage Today:

☐ Relaxation – focus on:_____ ☐ Specific condition or problem ➔ Please detail below

Specific Condition or Problem :

Exact location of Problem:

Cause/Reason:

Duration of Problem: ___ Years ___ Months ___ Weeks ___ Days

Type of Pain: Frequency: Intensity of Pain 1 to 10 (10 being the strongest):

What makes it better / worse?

ADL Limitations:

Other Treatments ☐ NO ☐ Yes

Notes:

Client Consent & Signature

This is to confirm and acknowledge that the abovementioned information is accurate to my knowledge. I give consent for treatment by a student massage therapist and have the right to withdraw consent at any time. The student has explained the treatment plan to me. I will communicate information, such as pain or discomfort levels, throughout the session to ensure my own safety and effectiveness of the session. I acknowledge that there may be post treatment effects including muscle soreness and tenderness. As part of this student massage treatment I agree to be available for contact, using the details above, in order to verify this treatment has taken place. I consent to ALG using and storing this information for assessment purposes in accordance with the ALG Privacy Policy.

Signed _____ Date _____

Assessment (postural and other)

Massage Treatment Details

Type of Massage:	☐ Swedish	☐ Remedial	☐ Sports	☐ Other ➔	
Duration	☐ 1 hour	☐ 1 ½ hours	☐ 2 hours	☐ Other ➔	
Areas Worked On:	☐ Upper Back	☐ Lower Back	☐ Head	☐ Neck	☐ Shoulder
	☐ Arms	☐ Abdomen	☐ Legs	☐ Feet	

Details

What was Found

Precautions Taken

Advice Given / Referral

Student Details

Student Name:_____ Signature: _____ Date:_____