NSW SCHOOL of MASSAGE

Client Case History Form

(to be completed by student on behalf of client)

Date & Time: ☐ Returning Client ☐ First Time Visitor ☐ 1 hour ☐ 2 hours Have you had massage before? ☐ Yes ☐ No Type:

Client's Personal Information

Name

Contact Phone ☐ Male ☐ Female

Date of Birth Occupation

Email

Medical History / Contraindications

Injuries	☐ NO	☐ YES	➔ Please indicate injury in table & notes
Medical Conditions	☐ NO	☐ YES	➔ Please indicate medical conditions & notes
Medications	☐ NO	☐ YES	➔ Please indicate reason in notes below
Allergies to oils/creams/other	☐ NO	☐ YES	➔ Please indicate reason in notes below
Pregnant	☐ NO	☐ YES	➔ Indicate how many weeks below
Physically active	☐ YES	☐ NO	➔ Indicate details below
Exercise	☐ YES	☐ NO	➔ Indicate details below

INJURIES	☐ Recent Surgery	☐ Bruising
☐ Broken Bones / Fractures	☐ Inflammation	☐ Burns
☐ Sprains/Strains	☐ Dislocations	☐ Other
MEDICAL CONDITIONS	☐ High / Low Blood Pressure	☐ Asthma
☐ Herniated Disc / Bulging Disc	☐ Skin Conditions	☐ Cancer
☐ Numbness / Tingling	☐ Open Sores	☐ Diabetes: ☐ Type I ☐ Type II
☐ Osteoporosis	☐ Contagious Conditions	☐ Epilepsy
☐ Scoliosis	☐ Infection	☐ Lymphoedema
☐ Heart Conditions	☐ Fever	☐ Vertigo / Dizziness
☐ Blood Clots / DVT	☐ Headaches / Migraines	☐ Stress / Anxiety
☐ Bleeding Disorders	☐ Recent Illness	☐ Sleep Disorders
☐ Varicose Veins	☐ Arthritis	☐ Other

Notes

Reason for Massage Today:

Purpose for treatment 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.

Signed _____ Date _____

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OPRS Objective Assessment – *to be completed by Advanced Remedial Massage students only*

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:_____

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