Otago Polytechnic Massage Therapy Clinic
Client Details form

To be completed by client: Date:.....

Surname:..... First Name:.....

Preferred name:..... M/F ..... DOB:.....

Address:..... Contact details: Phone (H)..... (W) .....

..... Cell phone: .....

..... E-mail:..... .....

Occupation:.....

Referred by:..... Doctor/GP: .....

Previous experience with massage: ....

Please mark (X) all conditions that apply now, (P) for past conditions

	Allergies, sensitivity		Heart, circulatory problems		Pregnancy
	Arthritis (Osteo / Rheumatoid)		Hemophilia		Psychological conditions
	Asthma / Breathing difficulties		Hepatitis		Recent Injury / Surgery
	Blood clots / thrombosis		Hernia		Skin conditions, athletes foot
	Cancer, tumors		High/low blood pressure		Sleep problems
	Constipation/diarrhoea		Infectious disease		Spinal disorder
	Depression		IUD (birth control)		Tension, stress
	Diabetes		Joint Replacement / Pins		Vision impairment
	Digestive / Abdominal problems		Multiple sclerosis		Whiplash
	Dizziness / Fainting		Numbness or tingling		**Other medical conditions**
	Epilepsy		Organ Failure		
	Fatigue		Osteoporosis		
	Head injury		Pain (long-term / chronic)		
	Headaches, migraines		Pain (short-term / acute)		
	Hearing impairment / aid		Pacemaker		

Viral Condition (If Yes, please identify):

Explain any conditions noted above:

.....

.....

.....

Current Stress Level : 0 1 2 3 4 5 6 7 8 9 10
no stress medium very high

Medication (prescription and non-prescription): .....

.....

Surgeries:.....

.....

Accidents:.....

.....

Please list all forms of regular exercise, sports participation or other hobbies:.....

.....

.....

.....

Your rights under the Privacy Act:
This information has been requested in order to provide you with a safe and appropriate massage. Your details are confidential, they will not be disclosed to anyone other than your massage therapist and when necessary teaching staff. You may access your form or request correction to it at any time.

I have read and agree with the terms of service. I confirm that all the above information is true & correct and consent to receiving massage therapy in the student clinic for any appointments in the year this form is dated.

Client Signature:..... **Date: …….**