

Aromatherapy / Reflexology

Client Personal Information



43 Thomas Street
Wynnum Qld 4178

Ph: 0408 220 125
E: info@mtah.com.au
www.mtah.com.au

ABN: 75 237 121 948

Name: _____

Address: _____

Phone: _____

Email: _____

Date of Birth: ____ / ____ / ____

Occupation: _____

Reason for visit: _____

Current Medical Conditions: _____

Current Medical Practitioner details: _____

Fractures / Accidents / Operations: _____

Do you smoke? _____ How many per day? _____

Do you wear contact lenses? _____

Do you have any implants? (pacemaker, pins etc.) - _____

Emergency Contact

Name: _____ Phone: _____

Please detail any relevant Family Medical History:

Mother: _____ Father: _____

Siblings: _____



Moore Than A Healing
Connecting MIND BODY SPIRIT

Please indicate & provide details if you have any of the following conditions

Blood Pressure – Please circle appropriate: HIGH / LOW / NORMAL / UNSURE

Heart Problems: _____

Asthma / Respiratory Conditions: _____

Thrombosis / Circulatory Conditions: _____

Fainting / Blackouts / Vertigo: _____

Stroke: _____

Varicose Veins: _____

HIV Positive / AIDS: _____

Sciatica / Lumbago / Back Pain: _____

Joint pain / discomfort: _____

Diabetes & Type: _____

Epilepsy: _____

Cancer: _____

Problems or conditions with any organs: _____

Reproductive Problems: _____

Fluid retention _____

Skin Conditions: _____

Allergies: _____

Pregnant – how many weeks?: _____

Diagnosed Mental Health Condition: _____

Anxiety / Panic Attacks / Social Phobia: _____

Stress Indicate Level (1 – 10, 1 being mild to 10 being extreme) _____

Medications or supplements: _____

I understand that the Massage or Aromatherapy treatment received is provided for the purpose of relaxation and relief of muscular tension. If I receive any pain or discomfort during the treatment I will immediately inform the therapist so that treatment may be adjusted accordingly. I also understand that the treatment should not be considered a substitute for medical examination or diagnosis. I understand that the massage therapist is not qualified to perform spinal or skeletal adjustment, diagnosis or treatment of specific mental illness. As massage should not be performed if certain conditions exist, I affirm that I have stated all my known medical conditions and have answered all questions honestly. I agree to keep the therapist informed and updated of any changes in my medical conditions at future treatment sessions and understand that there will be no liability on the therapist should I fail to do so.

Name: _____ **Date:** ____ / ____ / ____

Signature: _____

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