Tarrengower Remedial Massage

From: Squarespace <form-submission@squarespace.info>
Sent: Thursday, 7 September 2023 5:41 PM
To: tarrengowerrm@gmail.com
Subject: Form Submission - Client-History-form

Sent via form submission from *Tarrengower Remedial Massage*

Name: Amanda Fedorowicz

Identify as: Female

Email: info@amandarichmond.com.au

Contact phone number: 0418534792

ddress: 2-6 High Street, Maldon Victoria 3463, Australia

Date of Birth: 04 December 1959

Occupation: Interior designer

What sports and/or activities do you do?: Golf,dancing,step aerobics,walking,cycling ,gardening

Health Fund?: Nib

Health fund Extras cover?: Yes

Emergency Contact name: Andrew Fedorowicz

Emergency contact phone number: 0418341443

Do you have any limitations for treatment?: No

Details of limitations if previous answer is yes:

What are your expectations for treatment?: Back strain relief.

Is there a possibility that you are pregnant: No

Do you have varicose veins?: No

Do you have sunburn?: No

Have you had any recent surgery or do you have scar tissue?: No

Details if answer to previous question is yes.:

Do you have any inflamed or painful areas?: Yes

Details if answer to previous question is yes.: Lower back strain

High or Low Blood Pressure: Normal

Do you have a circulatory disorder?: No

Do you take supplements?: No

Details if answer to previous question is yes.:

Do you have arthritis?: No

Details if answer to previous question is yes.:

Do you have any allergies?: No

Details if previous answer is yes.:

Do you have diabetes?: No

Have you ever had blood clots or been diagnosed with DVT?: No

Have you had any fractures or dislocations: No

Details if previous answer is yes.:

Do you suffer from headaches or migraines?: No

Do you have cancer?: No

Details if previous answer is yes.:

Do you have any infectious conditions?: No

Are you taking any medications?: Yes

Details if previous answer is yes.: 2.5 mg livial

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Consent for Treatment
I understand that:

- This is a massage treatment and is not a medical or allied health treatment (physiotherapy, osteopathy, chiropractic)
- I have viewed the therapists' qualifications
- The risks specific to my individual circumstances may have a bearing on my decision to proceed with the proposed treatment
- The therapist reviewed my health history before treatment commenced
- The therapist explained that the physical assessment I received may involve partial undressing and may require the therapist to palpate (touch) the area(s) of my body relevant to my presenting condition
- The therapist explained the treatment options to me
- The therapist explained the associated risk and possible side effects with the treatment options as described
- The therapist discussed the massage procedures, the areas of the body to be treated, the undressing and dressing procedures, the draping procedures and the positioning on the table for and during treatment
- The therapist established that the treatment session will be stopped should the treatment as first agreed to, require modification. The therapist will explain the reason for the change and any risks and/or side effects as a result of the change
- I can ask any questions in regard to any modification to the treatment plan. I should be totally comfortable with the explanation and reasoning for the change before consenting to the modification to the initial treatment plan
- The therapist has explained that I have the right to refuse treatment, to make changes to the treatment and to stop the massage at any time
- I have the right to request evidence for treatment that may include the abdomen, anterior and lateral chest, and buttock and / or groin areas. I understand I have the right to refuse treatment of these areas
- If I agree to treatment to any of the areas mentioned in the point above, I may be requested, by the therapist, to complete a consent form relevant to those areas

Only sign below if the above information is understood and has occurred

Client
Name: AMANDA FEDOROWICZ Signature: [signature] Date: 19.9.23

Parent/Guardian
Name:_____ Signature:_____ Date:_____

Therapist
Name: Paul Gilders Signature:_____ Date:_____