New Zealand College of Massage - Client Information Sheet

Name: ______________________________ Date: ______________

Address: ______________________________

Phone: ______________ Mobile: ______________ Age ______________

Email ______________________________ Occupation ______________

How did you find out about the student clinic? ______________________________

Please tick box if you would **not** like to receive information about special clinic offers, career options and interest courses ☐

Please tick to indicate conditions that you are aware of that may be affecting your health:

Allergies-specify __________	☐	Epilepsy	☐	Mental illness	☐
Arthritis / Gout	☐	Fatigue / Exhaustion	☐	Numbness / Tingling	☐
Asthma / Breathing problems	☐	Fever / Flu / Viral Condition	☐	OOS / RSI	☐
Cancer -specify __________	☐	Headaches / Migraines	☐	Pregnancy (wks.) __	☐
Chronic Pain Conditions	☐	Heart Condition / Chest Pain	☐	Sleep Disturbance	☐
Diabetes	☐	Hepatitis A/B or C, HIV	☐	Stroke	☐
Digestive Problems	☐	Hernia / Ulcer	☐	Swelling / Fluid Retention	☐
Dizziness	☐	High / Low Blood Pressure	☐	Thrombosis / Blood Clots	☐
Easy Bruising	☐	Inflammation	☐	Varicose Veins	☐

Do you currently have any of the following skin conditions?

Rashes, open wounds, burns, psoriasis, eczema, fungal conditions, warts, verruca, cold sores, skin ulcers ☐

Do you wear contact lenses, glasses or hearing aids? ☐

Please list past operations & serious injuries e.g.: Joint Replacements: ______________________________

____

Do you have any other condition(s) we should know about that may impact on your experience of massage?

____

Are you currently receiving any other type of treatment and/or taking medication? Please List:

____

If any of the above conditions are ticked, students will obtain further details to determine safety. A medical clearance from your GP or health practitioner may be necessary for massage to proceed, and in some cases massage may not be the most suitable form of treatment for you at this time. **Clearance obtained for massage** (written or verbal) below – attach if applicable.

GP/HP Name: ______________________ Clearance Given: ______________________

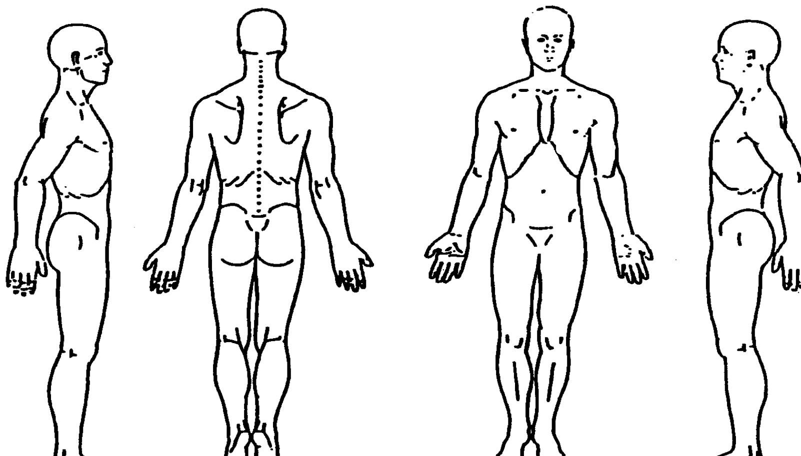
What physical activities/hobbies do you currently participate in? ______________________________

____

Are you currently experiencing any **muscle tension, aches, or pain?**

Where?

Please indicate pain or tension areas on the picture, your therapist will discuss these with you.



Previous massage experience: Often ☐ At times ☐ Never ☐

Current Stress Levels: Low ———————————————— High

Current Pain/Tension: Low ———————————————— High

What are you hoping to achieve with massage? (e.g.: Release tension, relaxation, injury rehab, etc.)

____

____

Please let us know if there is any massage techniques that you find particularly effective or any aspect that you would like changed at any time throughout your session (e.g. pressure, speed, etc.)

Are there any areas that you would **not** like massaged? (E.g. Feet, head.)

____

Do you have any difficulty laying on your back/front/side? How can we make you more comfortable?

____

Welcome to the New Zealand College of Massage Student Clinic

The New Zealand College of Massage Student Clinic offers 1hr massage appointments with students, undertaking training in either Certificate in Relaxation Massage - 6 months, Diploma in Health Sciences (Therapeutic Massage) – 18 months, Diploma in Health Sciences (Massage and Sports Therapy) – 2 years, or Bachelor of Health Studies (Massage and Neuromuscular Therapy) – 3 years.

☐ I understand that the student clinic is primarily a learning environment for students to practice massage taught in a professional supervised setting. The students will stay within their scope of practice (level). They have access to a supervisor as required.
☐ I understand that supervisors will enter the room during the massage session and discuss with the session with the therapist.
☐ I understand that each massage session will include time for consultation & assessment so students appreciate your condition, to deliver an effective massage.
☐ I understand that my feedback is encouraged not only at the end but during the massage session as well. I understand that this is not only so that the student receives ongoing and constructive feedback but also so that I get the most out of the massage session.
☐ I understand that it is not always possible to see the same practitioner each time I attend the student clinic.
☐ I understand that payment must be made at the time of my appointment, if not beforehand.
☐ I understand the NZCM late arrival and cancellation policy (less than 24 hour notice of cancellation or booking changes may be subject to a cancellation fee. Massage session will not be extended due to late arrival)
☐ I understand that massage therapy is designed to be a health aid and does not take the place of Primary Care.
☐ I understand that I must contact the clinic and consult my health practitioner if I have medical conditions that become aggravated or if I have any severe or ongoing effects after the massage.
☐ I give permission for this information and my clinical records to be seen by clinical supervisors and may be shared between students at the New Zealand College of Massage.
☐ I consent to being contacted by the New Zealand College of Massage to gain direct feedback about my experience.
☐ I am aware I may experience mild discomfort, headaches or tiredness after the massage. This is a normal response to Massage. Post massage suggestions are to increase water intake and avoid strenuous exercise for 12 hours.

Please address any concerns or complaints firstly to the student/supervisor, then to NZCM, or if not resolved to The Health and Disabilities Commission, PO Box 1791, Auckland

I certify that I have read & completed this form to the best of my knowledge, and I give consent to proceed with a consultation & massage:

Client's signature: ______________________ Date: ____________

Student signature: ______________________ Supervisor Signature: ____________