Consultation Form - Body Massage

Name: **Profession/occupation:**

Address: **Tel No:**

PERSONAL DETAILS

Age group: Under 20☐ 20–30☐ 30–40☐ 40–50☐ 50–60☐ 60+☐

Lifestyle: Active☐ Sedentary☐

Last visit to the doctor:
GP Name:
Address:
No. of children (if applicable):

The following information is required for your safety and to benefit your health. It will also help us to provide a treatment that will best meet your individual needs. While massage is a very safe treatment there are certain conditions that may require special attention and it may be necessary for you to consult your GP before treatment can be given. Information will be treated in the strictest of confidence.

Do you have/have you ever suffered from:

Any condition already being treated by a GP or another complementary practitioner (please specify):

Cardio vascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions) ☐
Haemophilia ☐
Medical oedema ☐
Osteoporosis ☐
Arthritis ☐
Nervous/Psychotic conditions ☐
Epilepsy ☐
Recent operations ☐
Diabetes ☐
Asthma ☐
Varicose veins ☐
Cuts Bruises Sunburn ☐
Scar tissue (2 years for major operation and 6 months for a small scar) ☐
Immune system(prone to infections) ☐
Hormonal implants ☐
Menstruation (abdomen -first few days) ☐
Hernia ☐

Any dysfunction of the nervous system (e.g. Multiple sclerosis, Parkinson's disease, Motor neurone disease) ☐
Bell's Palsy ☐
Trapped/Pinched nerve (e.g. sciatica) ☐
Inflamed nerve ☐
Postural deformities ☐
Cervical spondylitis ☐
Kidney infections ☐
Slipped disc ☐
Undiagnosed pain ☐
Acute rheumatism☐
Undiagnosed lumps and bumps ☐
Localised swelling ☐

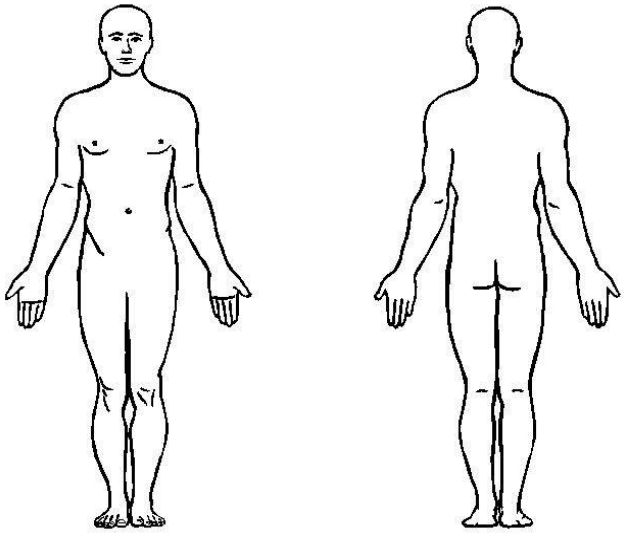
Inflammation ☐
Conditions affecting the neck ☐
Gastric ulcers ☐
Recent fractures (minimum 3 months) ☐
Taking prescribed medication ☐

Do you suffer from any of the following:

Skin diseases/ fever/contagious disease ☐
Cancer ☐
Are you under the influence of recreational drugs or alcohol ☐

Any other conditions that may affect the proposed treatment? ☐
Are you pregnant? ☐
Is GP referral required? yes ☐ no ☐

Please mark areas of pain



Client declaration:

I declare that the information I have given are correct and that I have not withheld any information concerning my health.

I have been informed about contraindications and I am willing to proceed with treatment.

I acknowledge that there is a possibility of developing some minor, temporary reactions following treatment.

I understand that massage is not a substitute for medical treatment.

Clients signed*:* **Date:**