

Consultation Form – Pregnancy Massage

Client Name: _____

Contact Details

Address: _____

Town: _____

Postcode: _____

Telephone: _____

Email address: _____

Date of Birth: _____

Medical Details

Doctors Surgery: _____

Doctors Name: _____

Current Medication: _____

Recent operations :(within last 6 months) _____

Family Medical History: _____

GP Referral Required? Y / N _____

Client Note:

The following details will be treated in the strictest confidence. It may, however, be necessary for you to consult your GP before the treatment can be carried out.

CONTRA-INDICATIONS - prevent / restrict treatment

<ul style="list-style-type: none">• The first three months of pregnancy <input type="checkbox"/>• High / low blood pressure <input type="checkbox"/>• Heart conditions <input type="checkbox"/>• Anaemia <input type="checkbox"/>• Varicose Veins <input type="checkbox"/>• Fractures <input type="checkbox"/>• Broken skin (cuts or abrasions), skin diseases or disorders – may cause irritation or cross contamination <input type="checkbox"/>• Foetus not in correct position <input type="checkbox"/>• Previous miscarriage(s) <input type="checkbox"/>	<ul style="list-style-type: none">• Warts / Skin tags / moles – avoid area <input type="checkbox"/>• Undiagnosed lumps or swellings <input type="checkbox"/>• Recent fractures, sprains or broken bones <input type="checkbox"/>• Metal pins or plates – avoid area <input type="checkbox"/>• Diabetes – seek medical approval dependant on client <input type="checkbox"/>• Cancer – can spread through lymphatic system <input type="checkbox"/>• Dysfunction or disorders of the nervous system (Multiple Sclerosis, Strokes, Parkinson's Disease) <input type="checkbox"/>• Bleeding or spotting <input type="checkbox"/>
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<ul style="list-style-type: none"> • Severe bruising <input type="checkbox"/> • History of thrombosis or embolism <input type="checkbox"/> • Recent haemorrhaging <input type="checkbox"/> • Recent scar tissue – within six months <input type="checkbox"/> • Recent operations • Sunburn / windburn – avoid area <input type="checkbox"/> 	<ul style="list-style-type: none"> • Risk of preeclampsia <input type="checkbox"/> • Any problems with the placenta <input type="checkbox"/> • Fever <input type="checkbox"/> • Nausea or diarrhoea <input type="checkbox"/> • Any condition currently being treated by their GP <input type="checkbox"/>
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SKIN ANALYSIS

Skin type? Dry Oily Combination Sensitive Dehydrated

Circulation: Good Average Poor

Do you suffer/have suffered from: Dermatitis Acne Eczema Psoriasis

Reason for treatment:

Client Note:The following information is required for your safety and to benefit your health. Whilst the treatment is totally safe when carried out correctly, there are certain contra-indications which require special attention.

The following details will be treated in the strictest confidence. It may, however, be necessary for you to consult your GP before the treatment can be carried out.

CLIENT DECLARATION

I declare that the information I have given is correct.

Signature:

Date: