Consultation Form

All clients are required to fill out a consultation form prior to their first initial treatment. This will enable me to assess certain health conditions (if any) so as to provide a safe and effective treatment to suit your needs.
Some health conditions may be contraindicated to massage and may require doctors permission.
I am pleased to be welcoming you on board as my new client. My aim is to achieve the best possible results for each individual.
All information given is kept **STRICTLY CONFIDENTIAL**.
The information below will be retained as part of your client record.
(Please complete as much as possible where appropriate)

Name:...

Address...

…..

Date of Birth...

Telephone No..

Email Address (Useful for any further advice, exercises etc.)..

Medical History/Operations...

Medication...

Present Health..

Musculo/Skeletal problems: Are you experiencing any Aches & Pains? Yes□ No □ If yes please specify below:

…..
Digestive Problems: Constipation □ Diarrhoea □ Bloating □Liver/Gall Bladder □ Stomach □ IBS □ Ulcers □

Circulation: Heart □ Blood Pressure □ Fluid Retention □ Tired Legs □ Varicose Veins □ Cold Hands and Feet □

Genito/Urinary: Kidney problems □ Cystitis □ Prostrate problems □ PMS □ Menopause □ HRT □ Pill □ Coil □ Other
Irregular Periods □ Heavy Periods□ Further Details...

Nervous System: Headaches □ Migraine □ Tension □ Stress □ Depression □ Sensitive □
Immune System: Prone to infection □ Sore Throats □ Colds □ Chest □ Sinuses □

Further Details...

Do you suffer from any skin disorders? Dermatitis □ Acne □ Eczema □ Psoriasis □ Allergies □.......................................
Asthma □ Details...

Reason for treatment:...

Professional Life (Job Details)..

Disclaimer

I accept that:
The information I have given is true to the best of my knowledge and I have not withheld any information concerning my health.
I understand that there is a possibility of developing some minor reactions – as my body adjusts to the treatment given.

I am also aware that there are contraindications to certain health problems/issues. While recognising that all due care will be taken by my therapist/practitioner, I am aware that my participation in the treatment is by my own choice.

Signed...
Write name...
Date...