

client details and consultation form



Name

Address

Date of birth

Email

Telephone

GP name and contact details

Do you have hypersensitive skin or any allergies? If yes, please give details

Are you currently taking any prescribed medication? If yes, please give details

Please tick if any of the following apply to you today

- | | |
|--|---|
| <input type="checkbox"/> Suffering from fever or contagious or infectious diseases | <input type="checkbox"/> Localised swelling or inflammation |
| <input type="checkbox"/> Consumed alcohol, recreational drugs or a heavy meal | <input type="checkbox"/> Gastric ulcer |
| <input type="checkbox"/> Diarrhoea and vomiting | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Undiagnosed lumps, bumps or pain | <input type="checkbox"/> Operations in the last two years |

If you have ticked yes to any of the above it may not be possible to proceed today with your treatment.

Please tick if any of the following apply to you

- Pregnant/planning a pregnancy
- Cardiovascular conditions (e.g. thrombosis, phlebitis (vein inflammation), high or low blood pressure, heart conditions)
- Haemophilia
- Currently being treated by a GP or another complementary practitioner
- Medical oedema (swelling)
- Osteoporosis
- Arthritis
- Nervous/psychotic conditions
- Epilepsy
- Diabetes
- Asthma
- Any dysfunction of the nervous system (e.g. Multiple Sclerosis, Parkinson's disease, Motor Neurone Disease)
- Trapped/pinched or inflamed nerve (e.g. sciatica)
- Cancer
- Kidney infections
- Hormonal implants
- Acute rheumatism
- Whiplash
- Slipped disc or cervical spondylitis

If you have ticked yes to any of the above you may need to obtain written medical permission from your GP or consultant confirming your suitability for receiving massage therapy, or sign a consent form prior to treatment.

