## client details and consultation form

Name	:thrive	
Address	· massage therap	
Date of birth	•••••••	
Email		
Telephone		
GP name and contact details		
<b>Do you have hypersensitive skin or any allergies?</b> If yes, ple	ase dive details	
Do you have hypersensitive skill of any attengles: If yes, please give details		
Are you currently taking any procesiond medication? If you	places give details	
Are you currently taking any prescribed medication? If yes, please give details		
Disease high if any of the fall aming a probate year hades.		
Please tick if any of the following apply to you today  Suffering from fever or contagious or infectious diseases	Localised swelling or inflammation	
Consumed alcohol, recreational drugs or a heavy meal	Gastric ulcer	
Diarrhoea and vomiting	Hernia	
Undiagnosed lumps, bumps or pain		
Undiagnosed tumps, bumps or pain	Operations in the last two years	
If you have ticked yes to any of the above it may not be pos	sible 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 infl	ammation), high or low blood pressure, heart conditions)	
Haemophilia		
Currently being treated by a GP or another complementar	y practitioner	
Medical oedema (swelling)		
Osteoporosis		
Arthritis		
Nervous/psychotic conditions		
Epilepsy		
Diabetes		
Asthma		
Any dysfunction of the nervous system (e.g. Multiple Scler	osis, Parkinson's disease, Motor Neurone Disease)	
Trapped/pinched or inflamed nerve (e.g. sciatica)		
Cancer		
Kidney infections		
Hormonal implants		
Acute rheumatism		
Whiplash		

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.

Please tick if any of the following apply to you	
Skin diseases Cuts, bruises, abrasions or sunburn	
Varicose veins Broken bone in the last 3 months	
If you have ticked yes, your treatment today may have to be modified to avoid certain areas of your body.  Please use this space to tell me anything else about your past or current health that you think could be useful for me to know	
Cuent name	
Client signature	Date
I have provided written consent from my healthcare pro	rapy to seek medical consent regarding my medical condition before proceeding with a massage therapy treatmentvider. healthcare provider and I sign below to confirm that I wish to
Client signature	
	ecurely stored in hard copy on this form with the purpose of ensuring my uture appointment need to be changed or cancelled. I understand that my nt is available on the Thrive website, or if requested, in hard copy from Nicola.
Date Notes/Amends	Signed

RG22 5JH



