MASSAGE CONSULTATION FORM

For the safety and effectiveness of your treatment please fill out the form accurately and with as much information as possible. All information is kept private and confidential.

PERSONAL DETAILS

Name _____

Address _____

_____

Telephone _____ Email _____

Date of Birth _____ Occupation _____

MEDICAL (please tick if you have any of the following conditions, If other give details)

Muscular/Skeletal: Osteoporosis ☐ Arthritis ☐ Acute rheumatism ☐ whiplash ☐ cervical spondylitis ☐ slipped disc ☐ fracture in the last 3 months ☐ postural deformities ☐ spastic conditions ☐ Aches and pains ☐

Cardiovascular: Hypertension ☐ Hypotension ☐ Thrombosis ☐ Heart Conditions ☐ Haemophilia ☐ Varicose Veins ☐ Haematoma ☐ Medical oedema. ☐

Neurological: Multiple sclerosis Parkinson's disease ☐ Motor neurone disease ☐ Bell's Palsy ☐ Trapped nerve e.g Sciatica ☐ Inflamed nerve ☐ Nervous or Psychotic conditions ☐ Epilepsy ☐ Migraines ☐

Skin: Psoriasis ☐ Eczema ☐ Contagious or infectious diseases ☐ Cuts ☐ Bruises ☐ Sun burn ☐ Athletes foot ☐ Verruca ☐

Digestive/Urinary: Hernia ☐ Gastric ulcer ☐ Irritable bowel syndrome ☐ diarrhoea ☐ vomiting ☐ kidney infections ☐

Respiratory/Endocrine: Asthma ☐ Hayfever ☐ Diabetes ☐

Reproductive: Pregnant ☐ Trying to conceive ☐ Hormonal implants ☐

General: Undiagnosed pain ☐ Lumps ☐ Bumps ☐ Swelling ☐ Inflammation ☐ Fever ☐ Cancer ☐ Recent operations. ☐

Other/further details _____

_____

_____

Do you have any allergies? _____

Are you taking any prescribed/over the counter medication? _____

_____

Do you have a condition being treated by a GP or complementary practitioner _____

_____

LIFESYLE

What type of exercise do you do? _____

_____

How would you describe your sleep patterns? _____

How would you describe your diet? _____

Do you smoke? _____ Do you Drink alcohol? _____

On a scale of 1 to 10 how would you describe your stress levels and why? _____

_____

TREATMENT PREFERENCES

(A full body massage will typically include the following areas of the body. Please circle if there are any areas you would prefer avoiding during the treatment.)

Back ☐ Shoulders ☐ Neck ☐ Arms ☐ Hands ☐ Gluteal muscles ☐ Legs ☐ Feet ☐
Abdomen ☐ Head ☐ Face ☐

Details _____

CONSENT TO MASSAGE

I Can confirm all information is accurate and correct

I understand that all the information I have provided will be treated in confidence and will not be disclosed to a third party without my written consent

I am aware of the contraindications to massage and I am willing to proceed with the treatment agreed.

Client Name _____ Client Signature _____

Date _____

Third Party Consent (for clients under 18) Name _____

Signature _____

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