Consultation Form

Client note:

The following information is required for your safety and to benefit your health. It will also assist me with providing a more holistic treatment that will meet your individual needs.

While massage is a very safe treatment, there are certain conditions that may require special attention. It may be necessary for you to consult your GP before treatment can be given.

All information given will be treated in the strictest of confidence.

General	
Client name:	GP name:
Address:	Address:
Tel number (day): (evening):	Tel number:
Email:	Date of consultation:
Date of birth:	
Occupation:	Sex: M/F
Marital status: single/married/separated/divorced/widowed	
Number of children/dependents (inc. ages):	

Medical - do you have/have you ever suffered from:		
	Y/N	Dates & details
* Current high temperature or fever		
Infectious/contagious disease		Eg, cold, flu, measles, mumps
Skin/scalp infections		Eg, herpes, impetigo, ringworm, scabies
Recent hemorrhage		
Are you currently under the influence of alcohol/drugs		Treatment can make you feel nauseous/dizzy while intoxicated
Recent head/neck injury		
Migraine		
** Recent surgery		
Severe heart condition		
Thrombosis/embolism		

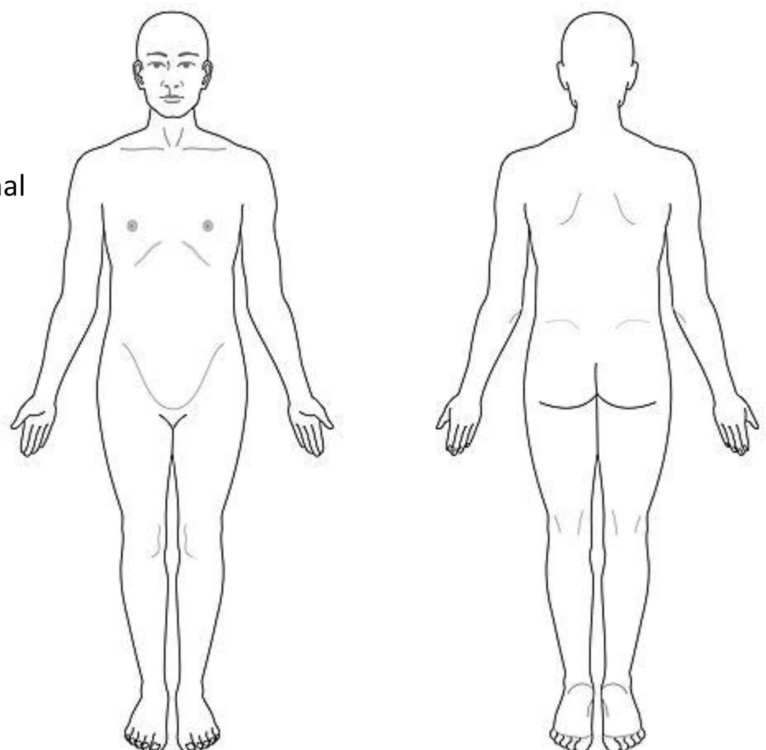
High/low blood pressure		High-prone to clots; both-prone to dizziness
Dysfunction of the nervous system		Eg, cerebral palsy, MS, Parkinson's
Epilepsy		Deep relaxation/overstimulation/smells can potentially trigger seizures
Diabetes		
Any fatal/terminal condition		
*** Recent scar tissue		
Open cuts/abrasion/severe bruising		
Skin disorders		Eg, eczema, dermatitis and psoriasis
Undiagnosed lumps/bumps/swelling		
Additional cautions:		
Allergies		Eg, nuts, soap powder
Asthma/bronchitis		
Pregnant		
Any other conditions that may affect the proposed treatment		
Relevant family medical history		
Current medication (prescribed & purchased)		Include dose
Is GP referral required?		(To be completed by therapist)

Reason for treatment: eg, relaxation, relieve stress, energise, muscular tension
Have you received complementary therapies before? If so, what and when?

X = focus points
* = contra indication type/area
* Total contra indication – treatment cannot be provided.

** Requires referral to GP/other professional before treatment can be given.

*** Localised contra indications – treatment to be avoided.



Lifestyle		
Stress levels	High/medium/low	
Energy levels	High/medium/low	
Daylight in workplace	Yes/no	
Sleep pattern	Good/average/poor	
Do you eat regular meals	Yes/no	
Do you eat in a hurry	Yes/no	
Well balanced diet	Yes/no	
Do you	skip meals/over-eat/binge/anything else	
Do you smoke	Yes: average per day	No
Do you drink alcohol	Yes: average units (daily/weekly)	No
Hobbies/creative interests:		
Relaxation:		
Exercise:		
Social activities:		
Do you have any pets:		
How did you hear about us:		

General health	
Digestive disorders	Constipation/diarrhea/flatulence
Muscular/skeletal problems	Neck/back/rheumatism/aches & pains/stiff joints
Immune system	Prone to infections/sore throats/colds/chest/sinuses
Nervous system	Sensitive/migraine/tension/stress/depression/anxiety

Client declaration:

I declare that the information I have given is correct and that I have not withheld any information concerning my health. I have been informed about contra-indications and I am willing to proceed with treatment. Participation in the treatment is by my own choice. I acknowledge that there is a possibility of developing some minor, temporary reactions following treatment. I understand that massage is not a substitute for medical treatment.

Client signature: **Date:**