Consultation Form — Body Massage

Personal Details

Name:	Title:		DOB:

Address:

Postcode:

Mobile: Tel (incl STD):

Email: ☐ Tick if you DO NOT wish to receive newsletters or offers

Occupation:

Doctor: Practice Address:

General State of Health

Do you smoke?	○ no	○ yes ____	cigarettes per day
Do you drink alcohol?	○ no	○ yes ____	units per week
How would you describe your stress levels?	○ high	○ medium	○ low
How would you describe your energy levels?	○ high	○ medium	low
Do you exercise regularly?:	○ no	○ yes	
Are you taking any medication?	○ no	○ yes	
Are you on any special diet?	○ no	○ yes	
Have you ever received a massage treatment before?	○ no	○ yes	
FEMALES ONLY - could you be pregnant?	○ no	○ yes	

FEMALES ONLY – Date of last period

_____

FEMALES ONLY - Have you had an IUD FITTED IN THE LAST 12 WEEKS?

○ no ○ yes

Conditions and/or Symptoms

Unstable blood pressure	○ no	○ yes	Osteoporosis	○ no	○ yes
Heart disorders	○ no	○ yes	Epilepsy	○ no	○ yes
Thrombosis/embolism	○ no	○ yes	Diabetes	○ no	○ yes
Skin Disorders	○ no	○ yes	Arthritis	○ no	○ yes
Recent haemorrhage	○ no	○ yes	Inoculations	○ no	○ yes
Back Problems	○ no	○ yes	Fever	○ no	○ yes
Swelling/Oedema	○ no	○ yes			

Dysfunction of nervous system (eg MS)	○ no	○ yes
Have you ever had or do you have cancer	○ no	○ yes
Do you have any recent fractures or sprains?	○ no	○ yes
Any infectious diseases (eg chicken pox)?	○ no	○ yes
Any allergies – ie to nuts, essential oils	○ no	○ yes
Any bruising, cuts, abrasions, varicose veins	○ no	○ yes
Recent surgery, broken bones, scarring	○ no	○ yes
Recently consumed alcohol?	○ no	○ yes
Recently consumed a heavy meal?	○ no	○ yes
Other conditions (eg ME)	○ no	○ yes

Please give details if answered yes to any of the questions to the left

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Treatment Plan

Name:

GP Referral Required ◯ no ◯ yes   Clearance Form Sent: ◯ yes Date Sent:
Clearance Form Sent: ◯ yes Date Received:

Client Declaration

I declare that the information that I have given is true and correct and that, as far as I am aware, I can undertake treatment with this establishment without any adverse effects. I have been fully informed about contra-indications and am willing, therefore, to proceed. I understand that facial massage therapy is not a substitute for medical advice and/or treatment.

Client's Signature: Date: Therapist's signature: Date:

Aftercare Advice:

Date:	Reason for Treatment:	Treatment Aim:	Medium:	Therapist:

Conclusion:	Comments:

Date:	Reason for Treatment:	Treatment Aim:	Medium:	Therapist:

Conclusion:	Comments:

Date:	Reason for Treatment:	Treatment Aim:	Medium:	Therapist:

Conclusion:	Comments:

Date:	Reason for Treatment:	Treatment Aim:	Medium:	Therapist:

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Date:	Reason for Treatment:	Treatment Aim:	Medium:	Therapist:

Conclusion:	Comments: