Consultation Form

Body massage

Personal Details

Name:

Address:

Postcode:

Occupation:

Emergency contact:

Tel:

Telephone (including code)

Day:

Evening:

Mobile:

Email:

Doctor:

Practice Address:

Postcode:

GP Practice:

General State of Health

Do you exercise regularly? ◯ no ◯ yes

Are you taking any medication? ◯ no ◯ yes

Are you on any special diet? ◯ no ◯ yes

How would you describe your stress levels? ◯ high ◯ medium ◯ low

How would you describe your energy levels? ◯ high ◯ medium ◯ low

Do you smoke? ◯ no ◯ yes, _____ cigarettes per day

Do you drink alcohol? ◯ no ◯ yes, _____ units per week

How would you describe your sleep patterns?

What do you do for relaxation?

Have you ever had a massage treatment? ◯ no ◯ yes

Reason for treatment?

Height:

Weight:

Date of birth:

Female clients:

Could you be pregnant? ◯ no ◯ yes, _____ weeks

Are you breast feeding? ◯ no ◯ yes

Date of last period?

Have you had an IUD fitted in the last 12 weeks? ◯ no ◯ yes

Conditions and/or Symptoms

Do you suffer from unstable blood pressure? ◯ no ◯ yes

Do you suffer from any heart disorders? ◯ no ◯ yes

Do you suffer from phlebitis? ◯ no ◯ yes

Do you have a history of thrombosis/embolism? ◯ no ◯ yes

Do you have epilepsy? ◯ no ◯ yes

Do you have a dysfunction of the nervous system? ◯ no ◯ yes

Do you suffer from any infectious diseases? ◯ no ◯ yes

Do you suffer from any skin disorders? ◯ no ◯ yes

Do you have any severe bruising? ◯ no ◯ yes

Do you have any recent scar tissue? ◯ no ◯ yes

Have you recently suffered from a haemorrhage? ◯ no ◯ yes

Do you have any varicose veins? ◯ no ◯ yes

Do you suffer from any swelling/oedema? ◯ no ◯ yes

Do you have any recent cuts or abrasions? ◯ no ◯ yes

Have you recently had any operations? ◯ no ◯ yes

Have you recently had any inoculations? ◯ no ◯ yes

Have you ever had or do you have cancer? ◯ no ◯ yes

Do you have any recent fractures or sprains? ◯ no ◯ yes

Are you currently suffering from a fever? ◯ no ◯ yes

Do you have diabetes? ◯ no ◯ yes

Do you have osteoporosis? ◯ no ◯ yes

Do you suffer from arthritis? ◯ no ◯ yes

Do you suffer from any back problems? ◯ no ◯ yes

Do you suffer from any allergies? ◯ no ◯ yes

Have you recently consumed alcohol? ◯ no ◯ yes

Have you recently consumed a heavy meal? ◯ no ◯ yes

Do you have any other medical condition? ◯ no ◯ yes

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

Section For Use By Therapist

GP consent required: ◯ no ◯ yes

Verbal consent obtained: ◯ no ◯ yes Client to sign and date declaration below

Written consent obtained (attach): ◯ no ◯ yes

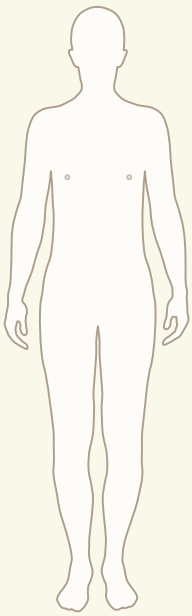
Client Declaration: I declare that the information that I have given is true and correct and that, as far as I am aware, I can undertake treatment with this establishment without any adverse effects. I have been fully informed about contra-indications and am willing, therefore, to proceed. I understand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

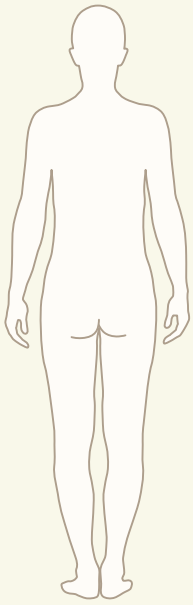
Client's signature: Date: Therapist's signature: Date:

Client name:

Treatment Plan

FRONT VIEW





BACK VIEW

Date:	Reason for Treatment:	Treatment Aim:	Medium:
Comments and aftercare advice:			Client feedback:
Therapist signature:		Date:	Client signature:
Date:	Reason for Treatment:	Treatment Aim:	Medium:
Comments and aftercare advice:			Client feedback:
Therapist signature:		Date:	Client signature:
Date:	Reason for Treatment:	Treatment Aim:	Medium:
Comments and aftercare advice:			Client feedback:
Therapist signature:		Date:	Client signature:
Date:	Reason for Treatment:	Treatment Aim:	Medium:
Comments and aftercare advice:			Client feedback:
Therapist signature:		Date:	Client signature:
Date:	Reason for Treatment:	Treatment Aim:	Medium:
Comments and aftercare advice:			Client feedback:
Therapist signature:		Date:	Client signature: