# Consultation Form

# Body Massage

## Personal Details

| Name: | Title: | | DOB: |
|---|---|---|---|
| Address: | | | |
| | Postcode: | | |
| Mobile: | | Tel (incl STD): | |
| Occupation: | | | |
| Email: | | Contact permission: Tick only if you wish to receive newsletters or promotional offers ☐ | |

Data Protection: Your data is treated as highly confidential by us. We will not share this with any one else unless it's for legitimate business purposes. For our full Privacy Policy visit www.modernmassagebeverley.co.uk

## 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 | Swelling/Oedema | no yes |
| Back Problems (not muscle) | no yes | Current Fever | no yes |
| Recent Vaccinations | no yes | Asthma | 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 you answered yes to any of the questions the left

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## Treatment Plan

Name:

GP Referral Required ◯ 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 facial massage therapy is not a substitute for medical advice and/or treatment.

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

Aftercare Leaflet Provided: ☐ Additional Aftercare Advice:

| Date: | Reason for Treatment: | Treatment Aim: | Medium: | Payment: |
|---|---|---|---|---|
| Comments: | | | | |
| Conclusion: | | | | |
| Date: | Reason for Treatment: | Treatment Aim: | Medium: | Payment: |
| Comments: | | | | |
| Conclusion: | | | | |
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| Comments: | | | | |
| Conclusion: | | | | |