

Consultation Form

**PERSONAL DETAILS**

Date:

Client Name:

Address:

Email:

Profession:

Tel. No: Day       Eve

DOB:

Lifestyle: Active Sedentary

No. of children (if applicable):

GP:

GP Address:

The following details will be treated in the strictest of confidence. It may, however, be necessary for you to consult your GP or specialist before any massage treatment can be given.

**CONTRAINDICATIONS REQUIRING MEDICAL PERMISSION** – in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment. *(select if/where appropriate):*

|  |  |
| --- | --- |
| Pregnancy | Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions) |
| Haemophilia | Any condition already being treated by a GP or another complementary practitioner |
| Medical oedema | Osteoporosis |
| Arthritis | Nervous/Psychotic conditions |
| Epilepsy | Recent operations |
| Diabetes | Asthma |
| Cervical spondylitis | Any dysfunction of the nervous system (e.g. Multiple Sclerosis, Parkinson’s disease, Motor neurone disease) |
| Bells Palsy | Trapped/Pinched nerve (e.g. sciatica) |
| Inflamed nerve | Cancer |
| Spastic conditions | Kidney infections/problems |
| Hormonal implants | Undiagnosed pain |
| When taking prescribed medication | Acute rheumatism/arthritis |
| Whiplash | Slipped disc |

**CONTRAINDICTIONS THAT RESTRICT TREATMENT** *(select if/where appropriate)*:

|  |  |
| --- | --- |
| Fever | Contagious or infectious diseases |
| Under the influence of alcohol or recreational drugs | Diarrhoea and vomiting |
| Skin diseases | Undiagnosed lumps and bumps |
| Localised swelling | Inflammation |
| Varicose veins | Cuts |
| Bruises | Abrasions |
| Scar tissue (2 years for major operation and 6 months for a small scar) | Sunburn |
| Abdomen (first few days of menstruation depending how the client feels) | Haematoma |
| Recent fractures (minimum 3 months) | Gastric ulcers |
| Hernia | Hypersensitive skin |

Do you have any other condition not mentioned above?

**WRITTEN PERMISSION REQUIRED BY:**

GP/Specialist  Informed consent

Either of which should be attached to the consultation form.

**PERSONAL INFORMATION** *(select if/where appropriate)*:

What is your general state of health?

Muscular/Skeletal problems: Back Aches/Pain Stiff joints Headaches

Digestive problems: Constipation Bloating Liver/Gall bladder Stomach

Ability to relax: Good Moderate Poor

Sleep patterns: Good Poor Average No. of hours:

Eating habits:

Do you smoke? No  Yes  How many per day?

Do you drink alcohol? No Yes How many units per day?

Do you exercise? None Occasional Irregular Regular Types

Any allergies?

Stress level: 1–10 (10 being the highest)

At work       At home

**Client declaration:**

I declare that the information I have given is correct and that as far I am aware I can undertake treatment without any adverse effects. I have been fully informed about the treatment and any contraindications and I am willing to proceed. I understand that any complementary therapy treatment does not substitute medical treatment.

Client Signature: ………………………………………………………….. Date: …………………..