PRIVATE AND CONFIDENTIAL MASSAGE CONSULTATION FORM

Name:	Age:	D.O.B:

Home Tel:	Address:
Mobile:	
Email:	
Occupation and Interests:	Where did you hear about the therapist?
	Name and number to contact in emergency:

Main reasons for seeking treatment:

CURRENT SPECIFIC MEDIAL CONDITIONS

Condition:	Duration of Condition:	Medication/Treatment received:

MEDICAL HISTORY

Serious illnesses:	Accidents:	Operations:

Do you or have you suffered with any of the following? (Please tick appropriate box and give details)

- ☐ High or low blood pressure
- ☐ Heart conditions
- ☐ Varicose veins
- ☐ Blood and circulatory disorder
- ☐ Headaches or Migraines
- ☐ Epilepsy or any other neurological dysfunction
- ☐ Sciatica
- ☐ Muscular aches and pains
- ☐ RSI
- ☐ Joint or back pain
- ☐ Asthma or respiratory disorder
- ☐ Skin disorder (i.e. eczema/acne)
- ☐ Infectious skin condition
- ☐ Dry or oily skin
- ☐ Constipation or diarrhoea
- ☐ IBS
- ☐ Kidney or urinary disorders
- ☐ Diabetes
- ☐ Cancer
- ☐ Allergies

Details:

P.T.O

LIFESTYLE INFORMATION			
Stress levels	High	Medium	Low
Energy levels	High	Medium	Low
General health	High	Medium	Low
Qualify of sleep	High	Medium	Low

Daily water intake:

Dietary supplements taken:

Exercise taken:

Other complimentary therapies used:

EMOTIONAL AND PSYCHOLOGICAL INFORMATION	WOMENS SECTION
Causes and manifestations of stress:	Menstrual problems (e.g. irregular, painful, PMT) Are you likely to be pregnant? Y/N Could you be menopausal? Y/N

Other information:

I confirm that the above information is correct and I have not withheld any information that could affect my treatment. I agree to notify Mandy of any changes in health or medication during subsequent treatments.

Print Name: Signature: Date: