Massage Consultation Form

Personal Details

Name: (Mr/ Mrs/ Mr/ Miss) _____

_____

Date of Birth: (DD/MM/YEAR) _____

Address: _____

_____

_____ Post code: _____

_____

Tel: (Home)_____ Mobile: _____

_____

Email Address: _____ Occupation: _____

_____

Emergency Contact: (NAME) _____

Relationship: _____

Tel Number: _____

Doctors Detail

Name: _____

_____

Address: _____

_____

_____ Post code: _____

_____

Tel Number: (Inc Area Code) _____

Life Style

Water intake: (Glasses/Day) _____

_____

Smoke: (Per Day) _____

_____

Alcohol: (Units/ Glasses- Week/Weekend) _____

_____

Exercise: (Daily/Weekly)___ _____

_____

General Health: (Scale 1 Low- 10-High) 1 2 3 4 5 6 7 8 9 10

Energy Levels: (Scale 1 Low- 10-High) 1 2 3 4 5 6 7 8 9 10

Hobbies/ Leisure: _____

_____

Family: (How Many children, partner) _____

_____

Relaxation: _____

_____

Life Changes: _____ Sleep Pattern: _____

_____

Diet: (food, healthy, take away) _____

_____

Female health: (Menstrual cycle, Pregnancy) _____

_____

Medical Details

Allergies: (medical, Hay Fever, Nuts, etc) _____

_____

Current Medication: (Contraceptive, General medication) _____

_____

Skin Conditions: (Eczema, psoriasis) _____

_____

Contraindications: Pregnancy Low Blood Pressure

Osteoporosis Epilepsy

Arthritis Seizures

Medication _____ Illness _____

Observations:

Movement: _____ Shape/Posture: _____

___

Skin Complexion: _____ Breathing: _____

____

Body:

Shape/Structure (Bones, Joints) _____ Crystals/ Lumps_____

____

Skin Texture: _____ Colouration: _____

_____

Odour: _____ Temperature: _____

_____

Treatment Plan

Reason for treatment: _____

_____

_____

_____

Previous Treatment: (Massage, Reflexology) _____

_____

_____

_____

Aftercare Advice

General advice: _____

_____

_____

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_____

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Specific Advice: _____

_____

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Treatment Agreement: I confirm that Kerry is able to hold this information confidentially and all this information is correct. I have not withheld any information that may be relevant to the treatment. I also understand that:

- This treatment is not being given as a substitute for any medical treatment
- The treatment does not promise to cure and condition or illness, but may aid recovery
- I will not be offering a diagnosis (A referral may be made if appropriate)

Client Signature: _____

Date: _____

Practitioners Signature: _____

Notes: _____

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Treatment Number: Date:

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