Consultation Form

Massage - Bodywork - Private Sessions

Client Name *

Client Address *

Occupation *

Contact Telephone Number *

Preferably Mobile Telephone

Client Email address *

Sex *

- ○ Female
- ○ Male

Date of Birth *

Number of Children (If Applicable)

GP NAME / LOCATION *

Date of last period (If Applicable)

Month Day Year

Contraindications that restrict treatment (Please tick where appropriate)

- ☐ Fever
- ☐ Contagious or infectious disease
- ☐ Under the influence of recreational drugs and/or alcohol
- ☐ Diarrhea or vomiting
- ☐ Skin diseases
- ☐ Undiagnosed lumps or swellings
- ☐ Localised Swelling
- ☐ Inflammation
- ☐ Varicose veins
- ☐ Pregnancy (abdomen)
- ☐ Cuts
- ☐ Bruises
- ☐ Abraisons
- ☐ Scar tissues (2 years for major operation and 6 months for a small scar)
- ☐ Sunburn
- ☐ Hormonal implants
- ☐ Abdomen (first few days of menstruation depending how the client feels)
- ☐ Haematoma
- ☐ Hemia
- ☐ Recent fractures (minimum 3 months)
- ☐ Cervical spondylitis
- ☐ Gastric ulcers
- ☐ After a heavy meal

Contraindications (Please tick where appropriate)

- ☐ Pregnancy
- ☐ Cardio vascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)
- ☐ Haemophilia
- ☐ Any condition already being treated by a GP or another health professional, e.g. Physiotherapist, Osteopath, Chiropractor, Coach
- ☐ Medical oedema
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Nervous/Psychotic conditions
- ☐ Epilepsy
- ☐ Recent operations
- ☐ Diabetes
- ☐ Asthma
- ☐ Any dysfunction of the nervous system (e.g. Muscular sclerosis, Parkinson's disease, Motor neurone disease)
- ☐ Bells Palsy

- ☐ Trapped/Pinched nerve (e.g. sciatica)
- ☐ Inflamed nerve
- ☐ Cancer
- ☐ Postural deformities
- ☐ Dysfunctions of the nervous systems (e.g. cerebral palsy/sroke/ Multiple sclerosis
- ☐ Kidney infections
- ☐ Whiplash
- ☐ Slipped disc
- ☐ Undiagnosed pain
- ☐ When taking prescribed medication
- ☐ Acute rheumatism

Personal Information

Please tick or answer where appropriate

Muscular/skeletal problems

- ☐ Back
- ☐ Aches/pains
- ☐ Stiff joints
- ☐ Headaches

Digestive Problems

- ☐ Constipation
- ☐ Bloating
- ☐ Liver/Gall bladder
- ☐ Stomach

Circulation

- ☐ Heart
- ☐ Blood pressure
- ☐ Fluid retention
- ☐ Tired Legs
- ☐ Varicose Veins
- ☐ Cellulite
- ☐ Kidney problems
- ☐ Cold hands and feet

Gynaecological

- ☐ Irregular periods

- [ ] PMT
- [ ] Menopause
- [ ] HRT
- [ ] Pill
- [ ] Coil

Nervous System

- [ ] Migraine
- [ ] Tension
- [ ] Stress
- [ ] Depression

Immune System

- [ ] Prone to infections
- [ ] Sore throats
- [ ] Colds
- [ ] Chest
- [ ] Sinuses

List any Antibiotics/Medication taken

List any Herbal remedies taken

Ability to relax

- ○ Good
- ○ Moderate
- ○ Poor

Sleep quality

- ○ Good
- ○ Poor

Average hours sleep per night

How many hours a day do you work at a computer?

Do you eat regular meals

- ○ Yes
- ○ No

How many units of these drinks do you consume per day

	Qty
Tea	
Coffee	
Fruit Juice	
Water	
Soft Drinks	

Please list any food allergies

Do you smoke? If So how many cigarettes do you smoke daily

Do you drink? If so how many units of alcohol do you consume per week?

Do you exercise? If so how many times per week?

Do you suffer or have you suffered from

- ☐ Dermatitis
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Allergies
- ☐ Hay Fever
- ☐ Asthma
- ☐ Skin Cancer

Stress levels at home (10 being highest)

1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○

Stress levels at work (10 being highest)

1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○

Right or Left Handed

- ○ Right
- ○ Left

Sport Details

If you are attending for a Sports Massage or Sports related private session, please fill in the following section.

What sports/activities do you participate in?

What is your main sport/activity

How long have you been doing this?

How often do you play/train per week

What is your preferred position/discipline/distance within your sport?

Please list any injuries sustained whilst participating in your sport or activity

Disclaimer Form

Please read the following and tick the appropriate box, by ticking the box you are confirming you are in full agreement with the statements contents.

Please read the following information , tick and sign below: *

- ○ I understand that although massage therapy, bodywork and movement sessions can be therapeutic, relaxing and enhance body mobilisation, it is not a substitute for medical examination, diagnosis and treatment
- ○ This is a professional session and at anytime my therapist has the right to end the session if they feel uncomfortable
- ○ I confirm that I have answered all the questions to the best of my ability and that I have not withheld any information regarding my medical history or conditions
- ○ I understand that certain medical conditions require GP or Consultant approval, before massage or movement is undertaken. And I have or am willing to seek this if required.

Client Full Name *

Date

Day Month Year

Parental Consent (Where Applicable)

To be completed by Parent or Guardian if client is under the age of 18.

By signing below, you agree that you are the parent or legal guardian of the minor receiving treatment(s) and consenting to the treatment recommended by the therapist. You understand that you are required to remain at the facility for the entirety of the minor's treatment(s). You will also be required, if needed, to assist the minor in preparing for his/her treatment(s). We also request that you remain in the treatment room to supervise all interactions between the therapist and the minor.You also agree that you have completed the Consultation Form and have informed the therapist of all medical diagnoses, symptoms, medications, and complaints associated with the minor receiving treatment(s).

○ I Agree

Parent/Guardians Full Name

Date

Day Month Year