CLIENT INFORMATION SHEET
ALL QUESTIONS ON THIS FORM ARE STRICTLY PRIVATE AND CONFIDENTIAL

Before completing this form please read below;

I am UNABLE to give you a Massage if you have any of the following;
If you are currently; Under the Influence of Drugs or Alcohol or have had an operation (anaesthetic) in the last 3-6 months. If you are currently suffering from; Fever, sore throat or cold, Active contagious infection, any viral infection, active Impetigo, Tinea Corpis or Pedis, Acute Bronchitis, Pleurisy, Pneumonia, Tuberculosis, Nephritis, Pyelonephritis, Migraine, Pre-Eclampsia, Hematoma, Acute High Blood Pressure, Active Hodgkin's, Shingles, Septicaemia, Hepatitis, have hormonal implants.
If you ever had; Thrombus, Thrombosis or Coronary Thrombosis,

I am UNABLE to give you Reflexology if you have any of the following;
An organ transplant, aneurysm, flebitis, arthritis in your feet,
If you are currently suffering from; Fever, sore throat or cold, Active contagious infection, any viral infection, Active Impetigo, Tinea Pedis,

Please note; There are instances where I cannot give you a massage but I can give you reflexology. If I need to amend your treatment I will inform you.

If you have cancer you may wish to consult with your oncologist before making an appointment with me.

PERSONAL DETAILS

Full Name

Address

Contact Tel

Email

Date of Birth

Age

Sex

Marital Status

Occupation

Name and Tel No of GP/Gynaecologist/Midwife

Name and number of person to contact in case of emergencies;

What are your reasons for coming to see me?

Have you received any holistic therapies in the past, if so what?

MEDICAL INFORMATION

What is your current state of your general health?

Are you currently seeing your Dr or any other specialist for treatment, if so please explain?

Do you have any allergies ie; Nut, washing powder etc

Any urinary tract, bladder infections within the last year?

Are you a heart patient?

Please tell me if you have any other serious medical conditions I need to know about ie; Cancer, Intravenous drug user;

What condition is your skin in Dry Oily Combination Sunburnt

Do you have any of the following;

Broken Bones	Eczema	Anaemia
Athlete's Foot	Psoriasis	High/low Blood Pressure
Verruca's	Osteoarthritis	Diabetes
Tendonitis	Acute Rheumatism	Haemophilia
Muscle Injuries	Kyphosis	Poor circulation
Recent Scar Tissue	Lordosis	Leukemia
Sinus problems	Scoliosis	HIV
Muscle Cramps	Back Pain	AIDS
Headaches	Gout	Chronic Fatigue Syndrome
Varicose Veins	Slipped Disc	Asthma
Poor Circulation	Torticollis	Breathing Difficulties
Arteriosclerosis	Ankylosing Spondylitis	Crohn's
Phlebitis	Migraines	Ulcers
IBS	Spasticity	Trapped Nerves
Constipation	Angina	Bells Palsy
Indigestion	Medical Oedema	Epilepsy
Heartburn	Kidney Stones	Nervous/Psychotic conditions

WOMEN ONLY

Are you pregnant? If so how many weeks? What is your due date?

Have you recently had a baby?

If so how was the delivery ie; C-section, epidural?

Number of pregnancies Number of miscarriages Number of terminations

Are you currently receiving fertility treatment, if so what sort?

How long is you menstrual cycle?

Are you pregnant or breastfeeding? Yes No

Have you had a D&C, hysterectomy or Caesarean? Yes No

Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around time of period? Yes No

Do you suffer from PMS? Yes No

Are you Menopausal? Yes No

Are you receiving HRT? Yes No

LIFESTYLE

Exercise

Sedentary (No exercise)

Mild exercise (i.e., climb stairs, walk 3 blocks, golf)

Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)

Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

What sort or exercise do you do?

Diet

Are you dieting? Yes No

No. of meals you eat in an average day?

Do you drink Caffeine? None No. of cups/cans per day? Coffee Tea Cola

How much water do you drink per day?

	Do you drink alcohol?			Yes	No
	If yes, what kind?				
	How many units per week?				
Tobacco	Do you use tobacco?			Yes	No
	Cigarettes – pks./day	Chew – No./day	Pipe – No./day	Cigars – No./day	
	No. of years		Or year quit		
Work	Is your work sedentary?			Yes	No
	Do you work in an air conditioned environment?			Yes	No
	Do you commute to work if so how?				
Stress	Rate your stress on a scale of 1 (being lowest) – 10				
	What areas of your life are causing you stress?				
	What do you do to relax?				
	What are your interests/Hobbies?				
	How many hours sleep do you get per night?				

DISCLAIMER

I agree that all the above information is correct to the best of my knowledge and I wish to go ahead with this treatment I have not withheld any information and if any of this information changes I agree to inform you immediately.

Signed by Client Date

Signed by Parent/Guardian Date

Signed by Therapist Date