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Massage Consultation Form

Client details

Name ________________________________ DOB ___________ Age________

Phone (day) ___________________________ Evening _____________________________

Email_________________________________ Occupation____________________________

Address_______________________________ Emergency Contact:

_____________________________________ Name_________________________________

Post Code_____________________________ Relationship ___________ Phone _________

Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking?

☐ Relaxation Other ☐ Therapeutic/Deep Tissue Other__________________

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

What are you hoping this treatment session will help with?

____

____

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please provide detail: ________________________________

Are there any areas you do not want massaged?

☐ yes ☐ no

☐ feet ☐ face ☐ abdomen ☐ Other____

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Medical information

Are you currently under the guidance of a doctor, consultant or other medical / health professional?

☐ yes ☐ no Are you taking any medications? ☐ yes ☐ no

If yes please provide details:

____

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Have you suffered from diarrhoea and/or sickness in the last 72 hours? ☐ yes ☐ no
Are you currently suffering from cold / flu / sinusitis? ☐ yes ☐ no

Please indicate any of the following that apply to you.

☐ Cancer
☐ Headaches/Migraines
☐ Osteoporosis
☐ Arthritis
☐ Diabetes
☐ Joint Replacement(s) / Joint Stiffness
☐ High/Low Blood Pressure
☐ Epilepsy
☐ Neuropathy
☐ Fibromyalgia
☐ Stroke
☐ Heart Attack / heart complaints
☐ Kidney Dysfunction
☐ Blood Clots
☐ Numbness
☐ Neck Pain
☐ Back Pain
☐ Sprains or Strains
☐ Other

Please provide some background on any conditions you have marked above:

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Women only
Are you currently pregnant? ☐ yes ☐ no If yes, how far along? ____________________

Declaration
By signing below, you agree to the following. I have completed this form to the best of my ability and knowledge, the information I have given is correct and as far as I am aware I can undertake treatments. I have been informed about the contra-indications and with this knowledge I am happy to proceed with this treatment. If at any point I or my therapist feels the need to obtain medical permission prior to the treatment then I declare I take full responsibility for my health and well being. I am fully informed about this treatment and have also received the necessary aftercare advice. I understand it is my responsibility to inform my therapist of any alterations in my health and well being.

Client Signature __________________________ Date __________

Therapist Signature __________________________ Date __________