Moray Massage Therapy

Your Name: _____

Your Address:

Consultation Date: _____

Telephone Numbers: _____ email: _____

Age: _____

Emergency contact name and number: _____

Do you have any allergies and what are they? _____

Are you or do you think you may be pregnant and if so what stage? _____

(Pregnancy Massage only) Have you checked with your doctor or midwife that massage is suitable for you? _____

Do you have Diabetes? _____

Do you have a Heart condition? _____

Are you taking blood thinning tablets? _____

Do you suffer from high blood pressure? _____

Are you taking medication? _____

Do you have any infection/verrucas/wart etc _____

Do you suffer from excess stress levels? _____

Are have having medical treatment? _____

Do you smoke? _____

Do you have difficulty sleeping? _____

What are you aims/reason for treatment? _____

Treatment areas: _____

Further information: _____

Have you had massage treatment before? _____

I confirm the details recorded during this consultation are correct. I have disclosed relevant information. If I have any medical concerns, I understand that I must consult a doctor (and/or midwife). The therapist has explained the treatment for which I give my consent.

Client signature:

Moray Massage Therapy

Follow up Consultation Date:

Name:

Has there been any changes to your medical or life-style since your last visit, including Covid ?

(Pregnancy Massage only) Have you checked with your doctor or midwife that massage is suitable for you?

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