

Oriental Holistic Massage women's Health & Concern Form 2021

Please note: The information on this form is kept strictly confidential

First Name:.....Surname:
 Postcode:
 Date of Birth: Contact Number :.....
Emergency contact and mobile number:
 Occupation:
 Email address:
 Reason for visit?.....
 How did you find our massage clinic?.....

Have you had, or are you currently suffering from, any of the following? Please tick the one you have.

Are you pregnant? Y/N	Cold/flu/fever	Infectious conditions	Aids
Varicose veins legs	Blood Clots	Diabetes	Hepatitis A, B, C
Headaches	Heart Ailments	Joint replacement	Skin Disorders
Depression	Heart pacemaker	Numbness	Shingles
Neck/spinal injury Y/N	Arthritis	Allergies	Epilepsy
High/Low Blood Pressure	Dizziness	Loss of Balance	Any Cancer.?

Trigger Point Therapy can leave some bruising on your skin if you bruise easy, do you still want trigger point therapy? Yes - No

Have you had a stroke and how long ago. Yes - No

Have you been in contact with anyone with Covid 19 or been in an area that is classed as a hot area? Yes - No

**Are you having cancer treatment now? _____
 If so, did you get the approval for massage from your cancer treating doctor? _____**

Please mark areas of pain (P) or injury (INY) or areas you do not want massaged (NTBM) on the chart below.

Other conditions not listed or you have said yes to a question?

Are you currently under any medical or health care treatment, taking medication, or have you had recent surgery?
 If so, please describe.....

Client Sign..... Date.....
 Massage Therapist Sign Date: