Consultation form

Name: D.O.B: Contact number:

Email:

Age group: Under 20☐ 20–30☐ 30–40☐ 40–50☐ 50–60☐ 60+☐

Lifestyle: Active☐ Sedentary☐

Last visit to the doctor:

GP address (If necessary):

Occupation:

Which week of pregnancy are you currently?

Have you ever had a massage/pregnancy treatment before? ☐ Yes ☐ No

If yes, what kind? ____

No. of children (if applicable):

Date of last period (if applicable):

CONTRAINDICATIONS REQUIRING MEDICAL PERMISSION – in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment. *(select if/where appropriate):*

WRITTEN PERMISSION REQUIRED BY *(select if/where appropriate):*

GP/Specialist ☐ Informed consent ☐

Either of which should be attached to the treatment form.

Pregnancy ☐

Cardio vascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions) ☐

Haemophilia ☐

Any condition already being treated by a GP or another complementary practitioner

Medical oedema ☐

Osteoporosis ☐

Arthritis ☐

Nervous/Psychotic conditions ☐

Epilepsy ☐

Recent operations ☐

Diabetes ☐

Asthma ☐

Any dysfunction of the nervous system (e.g. Multiple sclerosis, Parkinson's disease, Motor neurone disease) ☐

Bell's Palsy ☐

Trapped/Pinched nerve (e.g. sciatica) ☐

Inflamed nerve

Are you currently experiencing any of the following from your pregnancy?

Oedema ☐

Tiredness ☐

Muscle spasms/ cramps ☐

Breathlessness ☐

Fainting/ Dizziness ☐

Tender muscles ☐

CONTRAINDICTIONS THAT RESTRICT TREATMENT *(select if/where appropriate):*

Fever ☐
Contagious or infectious diseases ☐
Under the influence of recreational drugs or alcohol ☐
Diarrhoea and vomiting ☐
Skin diseases ☐
Undiagnosed lumps and bumps ☐
Localised swelling ☐
Inflammation ☐
Varicose veins ☐
Pregnancy (abdomen) ☐
Cuts ☐
Bruises ☐
Abrasions ☐
Scar tissue (2 years for major operation and 6 months for a small scar) ☐
Sunburn ☐
Hormonal implants ☐
Menstruation (abdomen -first few days) ☐
Haematoma ☐
Hernia ☐
Recent fractures (minimum 3 months) ☐
Gastric ulcers ☐
After a heavy meal ☐
Conditions affecting the neck ☐
Slipped disc ☐
Undiagnosed pain ☐
When taking prescribed medication ☐
Acute rheumatism ☐
Cancer ☐
Postural deformities ☐
Cervical spondylitis ☐
Spastic conditions ☐
Kidney infections ☐
Whiplash ☐
Slipped disc ☐
Undiagnosed pain ☐
When taking prescribed medication ☐
Acute rheumatism ☐

PERSONAL INFORMATION *(select if/where appropriate)*:

Muscular/Skeletal problems: Back ☐ Aches/Pain ☐ 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 ☐ P.M.T ☐ Menopause ☐ H.R.T ☐ Pill ☐ Coil ☐ Other

Nervous system: Migraine ☐ Tension ☐ Stress ☐ Depression ☐

Immune system: Prone to infections ☐ Sore throats ☐ Colds ☐ Chest ☐ Sinuses ☐

Regular antibiotic/medication taken? Yes ☐ No ☐ If yes, which ones

Herbal remedies taken? Yes ☐ No ☐ If yes, which ones

Ability to relax: Good ☐ Moderate ☐ Poor ☐

Sleep patterns: Good ☐ Poor ☐ Average No. of hours

Do you see natural daylight in your workplace? Yes ☐ No ☐

Do you work at a computer? Yes ☐ No ☐ If yes how many hours

Do you eat regular meals? Yes ☐ No ☐

Do you eat in a hurry? Yes ☐ No ☐

Do you take any food/vitamin supplements? Yes ☐ No ☐ If yes, which ones

Do you suffer from food allergies? Yes ☐ No ☐

Do you suffer from eating disorders? Bingeing? Yes ☐ No ☐ Overeating? Yes ☐ No ☐ Under eating? Yes ☐ No ☐

Do you smoke? No ☐ Yes ☐

Do you drink alcohol? No ☐ Yes ☐

Do you exercise? None ☐ Occasional ☐ Irregular ☐ Regular ☐ **What kind?**____________________________

What is your skin type? Dry ☐ Oily ☐ Combination ☐ Mature ☐ Young ☐ Normal ☐

Do you suffer/have you suffered from: Dermatitis ☐ Acne ☐ Eczema ☐ Psoriasis ☐ Allergies ☐ Hay Fever ☐ Asthma ☐ Skin cancer ☐

Stress level: 1–10 (10 being the highest)
At work: ☐ At home: ☐

Any current injuries?

Client profile/lifestyle/: NO NEED TO ANSWER

Treatment plan: NO NEED TO ANSWER

Date:

Clients Signature:

Business owner Signature: