MASSAGE CONSULTATION

Bodyworkz Massage Therapy

Sally Brant
Remedial Massage
Qualified and Insured
Dip. ITEC, Dip. BTEC

CLIENT INFORMATION

FIRST NAME:	MIDDLE:	LAST NAME:	TITLE:	DATE OF BIRTH:

Home phone no: Mobile: Email address:	Address:
Occupation and activities, including hours at desk/computer if applicable:	

GP's details in case of a medical emergency:	Contact details of friend/next of kin in case of emergency:
Doctor's name: Contact number(s): Address:	Contact's name: Relationship (friend/relative/spouse /partner): Contact number(s):

Are you receiving therapeutic treatment?
YES / NO
(if yes, please give details)

- ❑ Your doctor (GP)
- ❑ Complementary therapist
- ❑ Other

Do you take regular medication?
YES / NO
(if yes, please state reason):

Do you smoke?
YES / NO
(if yes, number per day)

Do you have any allergies?
YES/NO
(if yes, please tick)

- ❑ Nuts
- ❑ Cotton wool
- ❑ Tissues
- ❑ Other (If yes, state what):

Hours of sleep per night:

Quality of sleep (please circle):

Good | Average | Poor

Skin type:

- ❑ Dry
- ❑ Combination
- ❑ Oily
- ❑ Sensitive
- ❑ Dehydrated
- ❑ Normal

Stress levels: (please circle):
1 = least stressed, 10 = most stressed

1 2 3 4 5 6 7 8 9 10

Diet:
Do you eat a well balanced diet YES / NO. Does it include:

- ❑ Fresh fruit
- ❑ Protein
- ❑ Fresh vegetables
- ❑ Dairy

Do you exercise?
YES / NO
(if yes, please state type of exercise taken, and hours spent on it)

Fluid consumption: (please give an average of cups/glasses of what you drink each day)

Tea - Fruit juice -
Coffee - Water -
Soft drinks - Alcohol -

How did you hear of this service? (i.e. internet, referral, etc)	May Bodyworkz contact you with details of special offers/discounts for massage therapy, and occasional newsletters? (Your contact information will NEVER be passed on) **YES | NO**

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MEDICAL CONDITIONS

Do you have or have you ever had any of the following conditions?

☐ Anxiety	☐ Diarrhoea	☐ Migraines	☐ Scars
☐ Acute impetigo	☐ Difficulty swallowing	☐ Motor neurone disease	☐ Skin grafts
☐ Aches / pains	☐ Dizziness	☐ Muscle cramps	☐ Shingles
☐ Asthma / hay fever	☐ Ear problems	☐ Muscular sclerosis	☐ Sight problems
☐ Athletics foot	☐ Depression	☐ Neck pain	☐ Sinusitis
☐ Back pain	☐ Dermatitis	☐ Numb extremities	☐ Skin disorders
☐ Bereavement issues	☐ Eczema	☐ Operations	☐ Skin problems
☐ Blood clots	☐ Epilepsy	☐ Osteoporosis	☐ Sleep problems
☐ Blood pressure –high	☐ Fever	☐ Parkinson's disease	☐ Slipped disc
☐ Blood pressure –low	☐ Gastric ulcers	☐ Period problems	☐ Spastic conditions
☐ Breathing problems	☐ Headaches	☐ Pinched nerve	☐ Sprains / strains
☐ Broken bones	☐ Heart conditions	☐ Pins and needles	☐ Stroke
☐ Bruises / abrasions	☐ Hernia	☐ Pregnancy	☐ Thrombosis
☐ Cancer	☐ Herniated disc	☐ Psoriasis	☐ Varicose veins
☐ Cirrhosis of the liver	☐ Implants / stents	☐ Recent fractures	☐ Verruca
☐ Constipation	☐ Indigestion	☐ Rheumatism / arthritis	☐ Whiplash
☐ Cold extremities	☐ Joint pains	☐ Ringworm	☐ Any other conditions
☐ Diabetes	☐ Kidney infections	☐ Scabies	

Please give details of any condition for which you ticked the box above

Therapist signature ..... **Date** .....

(For reference)

Client signature ..... **Date** .....

(Confirmation of details)

Consent for Treatment

I confirm that the therapist has explained the treatment I will receive to me and I understand what it involves.

It has been offered to me as complementary to conventional medicine and I understand that it is not an alternative to or a replacement for any conventional therapy or medicine I require.

I have answered all medical and lifestyle questions put to me to the best of my knowledge and I participate in this therapy of my own free will and at my own risk.

My personal and medical information (both written and spoken) is confidential and will only be disclosed to third parties with my permission.

I will notify the therapist of any changes to this information given. I have been made aware of contra indications to treatment and possible contra actions and I am happy to proceed.

Client signature ..... **Date** .....