Massage Matters

CANCER TOUCH THERAPY CONSULTATION FORM

I need to gather some information from you to understand any health issues prior to treatment to ensure your receive a safe and appropriate massage. All information is completely confidential, will be stored securely, and will not be passed to any third parties.

YOUR PERSONAL DETAILS

Title: Mr Mrs Miss Ms Other	**First Name:**	**Surname:**
Address:		
Home Phone No:	**Work Phone No:**	
Mobile Phone No:	**Email Address:**	
How do you prefer to be contacted: Home Work Mobile Email		
Date of birth:		
Occupation:		
GP name and address:		

YOUR HEALTH TODAY

Are you currently suffering from, or have you very recently had:

a cold	flu-like symptoms	fever	rashes	severe migraines	diarrhoea
vomiting	swelling	Infection	lymphedema	inflammation	Excessive warmth

How are you feeling today both emotionally and physically?			
Are you in pain? Where?			
Are you able to:	lie on your front?	lie on your back?	sit in a chair for a seated treatment?
Are you using or wearing any medical devices today (dressings / prosthetics etc.). Are you happy to remove them?			

YOUR CANCER JOURNEY

Type of cancer (and locations)	Date of diagnosis	Stage

Type of treatment you are receiving	Date of last medical treatment	Medication
Side effects of medication	Lymph node dissection?	Sleep / tiredness levels

Please indicate if you are suffering from any of the following:

Back pain	YES / NO	Verrucas or viruses / fungal infections	YES / NO
High or low blood pressure or circulation problems (e.g. varicose veins)	YES / NO	Nervous (neurological) conditions	YES / NO
Heart conditions	YES / NO	Bone conditions (arthritis / osteoporosis)	YES / NO
Skin or hair conditions	YES / NO	Epilepsy	YES / NO
Respiratory (or sinus) issues	YES / NO	Diabetes	YES / NO
Do you have any allergies? Yes / No If yes, please describe.			
What skin type do you have – face and body? normal / oily / sensitive / dry / thin			
Do you have any other medical issues not mentioned so far that could impact on your treatment today?			
Have you had any major illnesses or operations in the last 2 years?			

MASSAGE

Have you had Cancer Touch Therapy before?	
Are there any areas of your body that don't want treated?	

CONFIDENTIALITY / DATA PROTECTION
Your details will be kept secure, not passed to any other therapists without your consent or to any third parties.
Please tick the box if you would like to be kept up to date on events or promotions. ☐

CANCELLATION POLICY
We reserve the right to charge a cancellation fee. If cancelled more than 48 hours in advance there will be no charge. Within 48 to 24 hours there will be a 50% charge. Within 24 hours we may charge the full amount of the treatment.

FEEDBACK / COMPLAINTS
I welcome any feedback in order to make treatments more beneficial. Please do talk to me if you have any issues, or if you would prefer, please fill in a feedback form. If you have a complaint, please talk to me directly, or if you would prefer, you can contact the Complementary Therapists Association on 0845 202 2941 or by email info@ctha.com

AGREEMENT / DISCLAIMER

The information I have given in this form is true to the best of my knowledge and I have not withheld any information concerning my health.
I understand that there is a possibility of developing some minor reactions as my body adjusts to any treatment given.
I recognise that all due care will be taken by my practitioner and that my participation is by my own choice.

Your signature and date

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