Massage Matters

CONSULTATION FORM

In order to commence giving you the best treatment possible I need to gather some information – this is to:

1) ensure you get the right treatment
2) discuss your expectations for treatment
3) understand any health issues prior to treatment to ensure it is safe for you to receive a 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:		

HEALTH

Are you currently suffering from, or have you very recently had: a cold / flu-like symptoms / fever / rashes / severe migraines / diarrhoea / vomiting / undiagnosed lumps or swellings / inflammation / cuts or bruises? YES / NO

Please indicate if you suffer from 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 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
How would you describe your state of health? poor / good / very good			
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			
Could you be pregnant? Yes / No			
Do you have any issues with being on a massage couch – getting on / lying down on front / turning over, etc.?			
Do you have any 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?			

STRESS AND RELAXATION

Do you have any hobbies that impact on your body relevant to treatments?	
What regular exercise do you do?	

DIET

How would you describe your diet? Very healthy Healthy Good Poor Unhealthy	
Do you smoke? Yes / No (If yes, how many daily / weekly)	
Alcohol (number of units a week)	Non-alcoholic liquid intake daily

MASSAGE

Are there any aspects of a treatment that you particularly like or dislike that could help ensure you get the best treatment today?	
Are there any areas of your body that don't want treated?	
What are you looking to get from today's treatment?	
What type of massage pressure do you prefer (if known)? (light / medium / strong)	

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 have also been made aware of contraindications. 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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