Massage
Consultation Form

Name:	
Address:	
Telephone Number:	
Email Address:	
Do you wish to be contacted by email about special offers and updates? Yes / No	

Date of Birth:	
Sex: M/F	
Name and Address of GP:	

Profession:	
Marital Status	
Children number and ages:	

Your health

Have you ever undergone an operation or will you be undergoing surgery (please give details)	
Are you or do you plan to undergo medical tests (please give details)	
Do you take medication (please give details)	
Any other medical history (please give details)	

Please state reason for attending massage treatments and your medical conditions:	

Contraindications/cautions - do you or have you ever suffered from (please circle):

Covid-19 Other Contagious Diseases DVT/Thrombosis Varicose Veins Phlebitis Inflammatory Conditions Arthritis Uncontrolled High Blood Pressure Hemophilia (issues blood clotting) Severe undiagnosed pain Haemorrhage Aneurysm Cellulitis Oedema (fluid swelling)

Diabetes Sunburn Unstable or replaced joints Recent Scar Tissue Cancer Severe Numbness Headaches Migraines Anxiety Depression Osteoporosis Heart conditions HIV/AIDS Hepatitis Epilepsy Bone fractures Dysfunction of the nervous system Severe bruising Sprains Allergies Stroke Muscular Spasms Irritable bowel syndrome Skin disorders Cuts in the affected area Fever Asthma Injuries

Lifestyle

Aches and Pains
Back Neck Shoulders Knees Stiff Joints
Rating of pain out of 10 (10 being the highest):

Stress
How would you rate your stress level on a scale of 1 to 10 (1 being the least stressed):

Sleep
How many hours on average do you sleep per night: Do you feel tired during the day:

Smoking
Do you or have you ever smoked: Yes/No If yes, how many do smoke per day or when did you stop:

Alcohol
Do you drink alcohol: Yes/No If yes, how many units do you drink per week and over how many days:

Exercise
Do you take regular exercise: Yes/No If yes, what type of exercise do you do:

Diet
How would you rate your diet: Poor Average Good Excellent Vegetarian Vegan:

Water Intake
Glasses/litres per day:

Females
Are you pregnant: YES/NO If yes, how many months:

How would you describe your menstruation: normal painful scanty irregular change of mood

Are you or have you undergone the menopause:

DECLARATION
I do not suffer from any medical problems other than the ones listed on this form. I agree to undertake the treatment(s) and I will seek medical approval from my GP should the situation with my health change.

I have seen the **online privacy notice** regarding use of my personal information. I understand that you will hold and use my personal information, using it in order to provide me with the best possible treatment options and advice in line with the statements above. I have read the **online Covid-19 advice** had a **Covid risk assessment** (www.relaxheel.co.uk).

Signature:……..

Date:……..