CONFIDENTIAL CLIENT CONSULTATION FORM

CONTACT DETAILS

Title ☐ **Mr.** ☐ **Mrs.** ☐ **Miss** ☐ **Ms.** ☐ **Other**

Name:……..Date of Birth:…….

Tel:.....Email:.....

CONTRAINDICATIONS REQUIRING MEDICAL PERMISSION ARE LISTED BELOW – in circumstances where medical permission cannot be obtained clients must give their informed consent. (Informed consent slip will be signed before treatment with the therapist).

If any apply to you please tick and give information in the space provided below to explain your condition/medication.

CONTRAINDICATIONS

MEDICAL DETAILS	Yes
Are you pregnant? No of weeks	
Are you on any prescribed medication?	
Cardio vascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart problems, heart attack	
Haemophilia	
Osteoporosis	
Arthritis	
Epilepsy	
Diabetes	
Asthma	
Any dysfunction of the nervous system (e.g. MS, ME ,motor neurone disease, bell's palsy	
Inflamed nerve	
Cancer	
Postural deformities	
Whiplash	
Slipped disc	
Kidney infections/problems	

CONTRAINDICATIONS THAT MAY RESTRICT TREATMENT

MEDICAL DETAILS	Yes
Recent operations/scar tissue (2yrs major, 6 months minor	
Contagious or infectious diseases	
Skin diseases	
Undiagnosed pain/lumps	
Inflammation	
Varicose veins	
Cuts/bruises/burns	
Sunburn	
Hernia	
Recent fractures (minimum 3 months)	
Verrucas or warts	
Gastric ulcers	

Please give details:

……

……

…… P.T.O.

Do you suffer with any back problems?
If yes please give details Yes ☐ No ☐

……

……

Are you undergoing treatment from an Osteopath, Chiropractor or Physio?
If yes please give details Yes ☐ No ☐

……

……

Would you like any areas of your body avoided?
If yes please give details Yes ☐ No ☐

……

……

What pressure do you prefer for your massage?

Light ☐ Medium ☐ Firm ☐

I have given all the above medical information to the best of my knowledge. If any circumstances change I will inform my therapist.

Client Signature..... Date.....

Client Name……..