



MESSAGE

Name:	Contact Number:
Address:	Date of Birth:
	Sex:
	Occupation:
	Hobbies:
Email Address:	
EMERGENCY CONTACT NAME:	Contact Number:
Relation:	

1.	How did you hear about us?	
		Please Answer: YES / NO
2.	Has your doctor ever said that you have any sort of heart trouble or defect?	
3.	Have you had a major illness or injury in the last 5 years?	
4.	Are you receiving treatment for any diagnosed medical condition?	
5.	Do you suffer from Thrombosis?	
6.	Are you taking any drugs or prescription medication?	
7.	Is your blood pressure.... Low/Normal/High	
8.	Do you lose your balance because of dizziness / do you ever lose consciousness, feel faint or dizzy?	
9.	Do you suffer from asthma, diabetes or epilepsy?	
10.	Have you ever been told that you have arthritic joints, osteoporosis or any bone or joint problem?	
11.	Do you often suffer from Headaches or Migraines?	
12.	Do you have pain or restricted movement in any other joints (e.g. hip, ankle, shoulder)?	
13.	Have you had major surgery in the last 10 years?	
14.	Have you had minor surgery in the last 2 years?	
15.	Are you, or could you be pregnant? If yes, when are you due?	
16.	Have you been pregnant in the last six months?	
17.	Do you have cancer or have you ever had cancer?	
18.	Do you currently have any open cuts or wounds?	
19.	Are you suffering from a fungal infection?	
20.	Have you consumed alcohol in the past 24hrs?	
21.	Do you have any allergies?	
22.	Are you displaying any symptoms of Covid-19?	

If you have answered **YES** to any of the above, please explain fully;

Please Provide details of your GP Surgery in case medical consent is needed before massage can be undertaken.

Doctors name:

Surgery name and address:

Phone number:

Important information

Please advise us before commencing any session if, for any reason, your health changes.

- The Massage Therapist can accept no liability for personal injury related to participation of a session if; Your doctor has, on health grounds, advised you against such treatments.
 - You fail to observe on health & safety.

I understand that Massage Therapy involves a hands-on-approach and I hereby consent for my practitioner to work in this way. I understand that it is my responsibility to inform the therapist if my medical needs/conditions change.

I confirm that I have read and understood the above advice and that the information is given is correct.

SIGNED:

CLIENT:.....DATE:.....

MESSAGE THERAPIST:.....DATE:.....