FHT
COMPLEMENTARY • BEAUTY • SPORTS

Body massage

Consultation form

Personal details

Name: _____

Address: _____

_____ Postcode: _____

Occupation: _____

Doctor: _____

Practice address: _____

_____ Postcode: _____

Telephone (day): _____

Evening: _____

Mobile: _____

Email: _____

Emergency contact: _____

Telephone: _____

GP practice tel: _____

General state of health

Do you exercise regularly? ○ Yes ○ No

Are you taking any medication? ○ Yes ○ No

Are you on any special diet? ○ Yes ○ No

Do you smoke? ○ Yes __ per day ○ No

Do you drink alcohol? ○ Yes __ units per week ○ No

How would you describe your stress levels? ○ High ○ Med ○ Low

How would you describe your energy levels? ○ High ○ Med ○ Low

How would you describe your sleep pattern? _____

What do you do for relaxation? _____

Have you ever had a massage treatment? ○ Yes ○ No

Reason for treatment? _____

Height: _____

Weight: _____

Date of Birth: _____

Female clients only

Could you be pregnant? ○ Yes __ weeks ○ No

Are you breastfeeding? ○ Yes ○ No

Date of last period? _____

Have you had an IUD fitted in the last 12 weeks?

○ Yes ○ No

Conditions and/or symptoms

Do you suffer from unstable blood pressure?	○ Yes	○ No	Have you recently had any operations?	○ Yes	○ No
Do you suffer from any heart disorders?	○ Yes	○ No	Have you recently had any inoculations?	○ Yes	○ No
Do you suffer from phlebitis?	○ Yes	○ No	Have you ever had or do you have cancer?	○ Yes	○ No
Do you have a history of thrombosis/embolism?	○ Yes	○ No	Do you have any recent fractures or sprains?	○ Yes	○ No
Do you have epilepsy?	○ Yes	○ No	Are you currently suffering from a fever?	○ Yes	○ No
Do you have a dysfunction of the nervous system?	○ Yes	○ No	Do you have diabetes?	○ Yes	○ No
Do you suffer from any infectious diseases?	○ Yes	○ No	Do you have osteoporosis?	○ Yes	○ No
Do you suffer from any skin disorders?	○ Yes	○ No	Do you suffer from arthritis?	○ Yes	○ No
Do you have any severe bruising?	○ Yes	○ No	Do you suffer from any back problems?	○ Yes	○ No
Do you have any recent scar tissue?	○ Yes	○ No	Do you suffer from any allergies?	○ Yes	○ No
Have you recently suffered from a haemorrhage?	○ Yes	○ No	Have you recently consumed alcohol?	○ Yes	○ No
Do you have any varicose veins?	○ Yes	○ No	Have you recently consumed a heavy meal?	○ Yes	○ No
Do you suffer from any swelling/oedema?	○ Yes	○ No	Do you have any other medical condition?	○ Yes	○ No
Do you have any recent cuts or abrasions?	○ Yes	○ No			

Please give details if you answered yes to any of the previous questions:

Section for use by therapist GP consent required? ○ Yes ○ No Verbal consent obtained? ○ Yes* ○ No *(client to sign and date declaration below)

Written consent obtained? (attach) ○ Yes* ○ No

Client declaration: I declare the information that I have given is true and correct and that, as far as I am aware, I can undertake treatment with this establishment without any adverse effects. I have been fully informed about contra-indications and am willing, therefore, to proceed. I understand that body massage is not a substitute for medical advice and/or treatment.

Client's signature: Date: Therapist's signature: Date: