**Client Consultation Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel no (Day): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: (D/M) \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This Consultation Form will assist your therapist in correctly evaluating your needs & choosing the correct treatment for you today. All information is strictly confidential & remains the property of ………………………………………………………………….

* Please indicate any recent or current experience of the following conditions:

|  |  |  |  |
| --- | --- | --- | --- |
| **Muscular/Joint** | **High Risk** | **Illness/Tension** | **Circulatory** |
| 🞏Recent/Repetitive Injury  🞏Whiplash | 🞏 Surgery  🞏 Heart Problem/Pacemaker | 🞏 Cold/Flu/Virus  🞏 Anxiety  🞏 Depression | 🞏 Blood Clots  🞏 Gout  🞏 Bruising |
| 🞏Joint Immobility  🞏Inflammation | 🞏 High/Low Blood Pressure | 🞏Chest/Breathing  🞏 Sleeping Problems | 🞏 Thrombosis  🞏 Oedema |
| 🞏Numbness/Tingling | 🞏 Digestive Problems | 🞏Asthma | 🞏 Varicose Veins |
| 🞏 Pain/Swelling | 🞏 Diabetes or Epilepsy | 🞏 Headaches |  |
| 🞏Fibromyalgia | 🞏 Cancer/Remission | 🞏 Dizziness |  |
| 🞏 Arthritis |  |  |  |

* Please list any physical or health conditions that your therapist should be aware of
* Please list any medication taken regularly and any specific medication/pain killers taken today
* What would you like to gain from your treatment today?

**FACE & BODY SECTION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 🞏 Allergies  🞏Pregnant/Breastfeeding | 🞏 Contact Lenses  🞏 Post Natal/Pre Menstrual | 🞏 Skin Sensitivity  🞏 Retin-A/Retinol | | 🞏 Claustrophobia  🞏 Heat Sensitivity |
| 🞏 Botox/ Dermal Fillers | 🞏Chemical Peels | 🞏 Menopausal |  | |

**MASSAGE SECTION**

* Does your main occupation include: 🞏 Desk/Computer work 🞏 Physical Activities 🞏 Travel
* Have you had a massage before? 🞏 No 🞏 Yes – when last? \_\_\_\_\_\_\_\_\_\_\_\_
* What type of massage would you prefer today: 🞏 Relaxing 🞏 Remedial
* Focus Areas: 🞏 Full Body 🞏 Upper Body 🞏 Lower Body 🞏 Hands & Feet 🞏 Scalp/Sinus
* Pressure: 🞏 Light 🞏 Medium 🞏 Firm 🞏 Deep 🞏 With Trigger Points

**GENERAL SECTION**

* How many glasses of water \_\_\_\_\_\_\_ caffeinated drinks \_\_\_\_\_do you drinking a day?
* What type of exercise are you doing regularly \_\_\_\_\_\_\_\_\_hrs per week\_\_\_\_?
* How do you feel today? 🞏 Energetic 🞏 Relaxed 🞏 Tired 🞏 Stressed 🞏 In Pain

**Please note it is not advisable to have a treatment if you have a fever, cold or flu symptoms.**

* How did you hear about us? 🞏 Word of Mouth 🞏 Internet 🞏 Walk by 🞏 Advertising

**Please agree to the terms and conditions below**

🞏 *I confirm that to the best of my knowledge, the answers I have given are correct and I have not withheld any information that may be relevant to my treatment. I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform my Therapist of my current medical or health conditions and to update this history as a current medical history is essential her/him to execute appropriate treatment procedures. I understand that the Clinic/Spa reserves the right to charge for appointments cancelled or broken without 24 hours notice*.

**Client Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_