# Consultation Form

## Personal Details

Name

 Telephone

Address

 Postcode

Email

Emergency

contact

Telephone

## General State of Health

Have you ever had massage treatment before? ⃝ Yes ⃝ No

Reason for

treatment?

Do you have a dysfunction of the nervous system?

⃝ Yes ⃝ No

Do you have diabetes? ⃝ Yes ⃝ No

Do you suffer from arthritis? ⃝ Yes ⃝ No

Do you suffer from any back problems? ⃝ Yes ⃝ No Do you suffer from any allergies? ⃝ Yes ⃝ No

Have you recently consumed alcohol? ⃝ Yes ⃝ No

Do you suffer from infectious disease? ⃝ Yes ⃝ No Have you recently consumed a heavy meal? ⃝ Yes

Do you suffer from a skin disorder? ⃝ Yes ⃝ no DO you have any severe bruising? ⃝ Yes ⃝ No Do you have any recent scar tissue? ⃝ Yes ⃝ No

Do you suffer from swelling / oedema? ⃝ Yes ⃝ No

Do you have any recent cuts / abrasions? ⃝ Yes ⃝

No

Have you had a recent operation? ⃝ Yes ⃝ No Have you recently had any inoculations?

⃝ Yes ⃝ No

## Conditions and or Symptoms

Do you suffer from unstable blood pressure? ⃝ Yes

⃝ No

⃝ No

Do you have any other medical condition? ⃝ Yes ⃝ No

## Female Client’s Only

Could you be pregnant? ⃝ Yes ⃝ No Are you breastfeeding? ⃝ Yes ⃝ No

Please give details below iff you answered yes to any of the questions

Do you suffer from any heart disorders? ⃝ Yes ⃝ No Do you have a history of thrombosis ⃝ Yes ⃝ No Do you have epilepsy? ⃝ Yes ⃝ No

Do you have any recent fractures or sprains?

⃝ Yes ⃝ No

Are you currently suffering from a fever?

⃝ Yes ⃝ No

Have you ever had or do you have cancer? ⃝ 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 affects. I have been fully informed about contra-indications and am willing, therefore to proceed. I understand that massage is not a substitute for medical advice and / or treatment.

## Client’s signature Date Therapist’s signature Date

MARKETING PREFERENCES FORM

Your personal information will only be used for treatment purposes and will not be shared with any third parties, without your express permission.

We would like to get in touch with you when we have information about new treatment and special offers that we think may be of interest to you. If you agree to be contacted in this way, please tick how you are happy to be contacted:

⃝ Yes ⃝ Email ⃝ Phone

If you have ticked one or more of the boxes above, please note that your data will only be used to send you future information about new therapies and special offers.

## You can change your preferences or remove your constant at any time by contact Ruth on: keywellnessuk@gmail.com

**Your name Date**