**Consultation Form**

**Massage Therapy by Nicola Wright**

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| **Name:** | **Mobile Number:** |
| **Email:** | **Occupation:** |

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| **Do you have or ever suffered from:** | **Y** | **N** | **Details** |
| High or Low Blood Pressure |  |  |  |
| Circulatory problems |  |  |  |
| Respiratory problems |  |  |  |
| Digestive problems (IBS etc) |  |  |  |
| Heart Condition |  |  |  |
| Chronic or serious illnesses |  |  |  |
| Epilepsy |  |  |  |
| Liver or Kidney complaints |  |  |  |
| Recent haemorrhage |  |  |  |
| History of thrombosis or embolism |  |  |  |
| Diabetes  |  |  |  |
| Are you pregnant, if so, how many weeks? |  |  |  |
| Any skin disorders or allergies |  |  |  |
| Are you on any medication? |  |  |  |
| Any discomfort/pain in your body? |  |  |  |
| What do you expect from this massage? |  |  |  |
| May I contact you with the details provided? |  |  |  |

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| **Client Declaration**“I, the undersigned have completed the form as fully and as accurate as I can. I believe the details to be correct and consent to having a treatment with Nicola. I release Nicola from the consequences of any negligent misrepresentation that may be contained in this form.” |
| Client Signature: | Date: |
| Therapist Signature: | Date: |

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| Area of pain: | Image result for massage consultation forms |
| Duration of pain: |
| Comments: |
| Appointment Dates/Notes: |