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

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

- Please list any physical or health conditions that your therapist should be aware of

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- Please list any medication taken regularly and any specific medication/pain killers taken today

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- What would you like to gain from your treatment today?

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<u>FACE & BODY SECTION</u>

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

<u>MASSAGE SECTION</u>

- 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: ____