

MEDICAL HISTORY (continued)

Please tick () all current conditions and mark past conditions with a **P**

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies/Asthma | <input type="checkbox"/> Any Contagious disease | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Cold/Flu | <input type="checkbox"/> Are you pregnant? | <input type="checkbox"/> Breastfeeding |
| <input type="checkbox"/> Any Skin Problem | <input type="checkbox"/> Spinal/Back Problems/Injuries | <input type="checkbox"/> Pain/Stiffness |
| <input type="checkbox"/> Heart Ailment | <input type="checkbox"/> Kidney Ailment | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Recent Illness/Surgery | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Cancer/Tumours |
| <input type="checkbox"/> TMJ Syndrome | <input type="checkbox"/> Breast Implant | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Car Accident | <input type="checkbox"/> Recent Fractures | <input type="checkbox"/> Other (please list) |

Details of any conditions that may affect the massage

Contact Name and Number in case of Emergency

Do you experience difficulty lying prone or supine (front or back)? Yes No

CLIENT DECLARATION

Consent is required to massage each part of the body, please indicate which areas you would like included:

- | | | | | | | | |
|-------------------------------|-----------------------------------|------------------------------------|-------------------------------|-------------------------------|----------------------------------|--------------------------------|----------------------------------|
| <input type="checkbox"/> Back | <input type="checkbox"/> Buttocks | <input type="checkbox"/> Legs | <input type="checkbox"/> Feet | <input type="checkbox"/> Arms | <input type="checkbox"/> Stomach | <input type="checkbox"/> Chest | <input type="checkbox"/> Breasts |
| <input type="checkbox"/> Face | <input type="checkbox"/> Head | <input type="checkbox"/> Shoulders | <input type="checkbox"/> Neck | | | | |

I recognize that there are contra-indications to massage (e.g. Cancer, Heart Problems, Thrombosis, Serious illness etc) and that all the information I have supplied is true and correct.

The therapist has explained the intended massage treatment and I fully understand and consent to the prescribed method and location/s of treatment.

Signature

Date

Would you like to be included on our mailing list? Yes No