MEDICAL HISTORY (continued)

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

☐ Allergies/Asthma	☐ Any Contagious disease	☐ Headaches
☐ Cold/Flu	☐ Are you pregnant?	☐ Breastfeeding
☐ Any Skin Problem	☐ Spinal/Back Problems/Injuries	☐ Pain/Stiffness
☐ Heart Ailment	☐ Kidney Ailment	☐ Diabetes
☐ Blood Pressure	☐ Epilepsy	☐ Arthritis
☐ Blood Clots	☐ Osteoporosis	☐ Chronic Pain
☐ Bruising	☐ Recent Illness/Surgery	☐ Numbness/Tingling
☐ Dizziness	☐ Joint Replacement	☐ Cancer/Tumours
☐ TMJ Syndrome	☐ Breast Implant	☐ Varicose Veins
☐ Car Accident	☐ Recent Fractures	☐ 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:

☐ Back ☐ Buttocks ☐ Legs ☐ Feet ☐ Arms ☐ Stomach ☐ Chest ☐ Breasts
☐ Face ☐ Head ☐ Shoulders ☐ 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 ☐

Sample Only

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