INNOVA THERAPIES
Holistic Massage & Facials

MASSAGE CONSULTATION FORM

For the safety and effectiveness of your treatment please fill out the form accurately and with as much information as possible. All information is kept private and confidential.

PERSONAL DETAILS

Name _____
Address _____

_____

Telephone _____ Email _____

Date of Birth _____ Occupation _____

MEDICAL (please TICK if you have any of the following conditions, **If other give details**)

Muscular/Skeletal: Osteoporosis ☐ Arthritis ☐ Acute rheumatism ☐ whiplash ☐ cervical spondylitis ☐ slipped disc ☐ fracture in the last 3 months ☐ postural deformities ☐ spastic conditions ☐ Aches and pains ☐

Cardiovascular: Hypertension ☐ Hypotension ☐ Thrombosis ☐ Heart Conditions ☐ Haemophilia ☐ Varicose Veins ☐ Haematoma ☐ Medical oedema. ☐

Neurological: Multiple sclerosis Parkinson's disease ☐ Motor neurone disease ☐ Bell's Palsy ☐ Trapped nerve e.g Sciatica ☐ Inflamed nerve ☐ Nervous or Psychotic conditions ☐ Epilepsy ☐ Migraines ☐

Skin: Psoriasis ☐ Eczema ☐ Contagious or infectious diseases ☐ Cuts ☐ Bruises ☐ Sun burn ☐ Athletes foot ☐ Verruca ☐

Digestive/Urinary: Hernia ☐ Gastric ulcer ☐ Irritable bowel syndrome ☐ diarrhoea ☐ vomiting ☐ kidney infections ☐

Respiratory/Endocrine: Asthma ☐ Hayfever ☐ Diabetes ☐

Reproductive: Pregnant ☐ Trying to conceive ☐ Hormonal implants ☐

General: Undiagnosed pain ☐ Lumps ☐ Bumps ☐ Swelling ☐ Inflammation ☐ Fever ☐ Cancer ☐ Recent operations. ☐

Other/further details _____

Do you have any allergies? _____

Are you taking any prescribed/over the counter medication? _____

_____

Do you have a condition being treated by a GP or complementary practitioner _____

_____

LIFESYLE

What type of exercise do you do? _____

_____

How would you describe your sleep patterns? _____

Stress levels (scale of 1 -10 and why)? _____

_____

TREATMENT PREFERENCES

Any areas to avoid? _____

light/medium/firm Pressure? _____

CONSENT TO MASSAGE

I Can confirm that all the information is accurate and correct
I understand that all the information I have provided will be treated in confidence and will not be disclosed to a third party without my written consent

Client Name _____ Client Signature _____

Date _____

CONTRAINDICATIONS (only if applicable)

I have discussed the following contraindication _____with my therapist

and I am happy to proceed with treatment. _____

I have gained verbal permission from my GP _____