Marsham Holistic Therapy

Holistic Massage Consultation Form

Name:.....

Date of Birth:.....

Address:

.....

.....

Contact Number.....

Occupation.....

Reason for having a massage.....

What massage pressure do you prefer (if known) Light Medium firm

Lifestyle:

Do you take regular exercise? Yes/No

How well do you sleep.....

Do you feel that Stress is causing you a problem? Yes/No

If yes on a level of 1-10 (10 being the highest) what level would you give your stress levels

A) At home B) At work

Are you seeing your G.P or another practitioner (e.g Chiropractor) currently and/or taking prescribed medication? Yes/No (please give details)

Very Important: Do you have any allergies i.e nut's? Yes/No If yes please give details

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Medical History

1) Do you get headaches? Yes/No (if yes how long do they last and what triggers them?)

2) Do any of the following apply to you? Please circle

Muscular problems e.g RSI, Sprains

Hormonal Implants

Varicose veins

Menstruating now or menopausal

Digestive system disorders e.g IBS, Crohn's

Known postural deformity e.g curved spine

Skin conditions e.g Eczema, Psoriasis

Whiplash injury / Neck condition

3) Please see contraindication's below and circle where necessary.

CONTRAINDICATIONS REQUIRING MEDICAL PERMISSION – in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment. ***(select if/where appropriate):***

Pregnancy
Cardio vascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)
Haemophilia
Any condition already being treated by a GP or another complementary practitioner
Medical oedema
Osteoporosis
Arthritis
Nervous/Psychotic conditions
Epilepsy
Recent operations
Diabetes
Asthma
Any dysfunction of the nervous system (e.g. Muscular sclerosis, Parkinson's disease, Motor neurone disease)
Bells Palsy
Trapped/Pinched nerve (e.g. sciatica)
Inflamed nerve
Cancer
Postural deformities
Kidney infections
Whiplash
Slipped disc
Undiagnosed pain
When taking prescribed medication
Acute rheumatism

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CONTRA-INDICTION'S THAT RESTRICT TREATMENT *(select if/where appropriate)*:

Fever
Contagious or infectious diseases
Under the influence of recreational drugs or alcohol
Diarrhoea and vomiting
Skin diseases
Undiagnosed lumps and bumps
Localised swelling
Inflammation
Varicose veins
Cuts
Bruises
Abrasions
Scar tissues (2 years for major operation and 6 months for a small scar)
Sunburn
Hormonal implants
Haematoma
Hernia
Recent fractures (minimum 3 months)
Cervical spondylitis
Gastric ulcers
After a heavy meal
Conditions affecting the neck

Any other medical condition or relevant family history of disease:

If anything in question 3 does apply to you please read and sign the relevant statement below:

The therapist has advised me to seek my G.P/Consultants permission to have massage. The possible implications of having massage without consulting my G.P/ Consultant have been explained to me.

I prefer to contact my G.P or consultant first prior to receiving treatment ☐

I give informed consent to treatment without confirmation from my G.P or consultant and indemnify Marsham Holistic Therapy against any adverse reaction sustained as a result of treatment ☐

I hereby consent to massage confirming that the information I have given is to my knowledge a true record of my health at this time. I understand that massage is not a substitute for medical attention

Clients Signature..... Date.....

Therapists signature..... Date.....

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Treatment record

Date:.....

Treatment plan:

Clients reactions / Areas of tension:

Date	Treatment plan	Reactions / areas of tension
Treatment 2		
Treatment 3		
Treatment 4		
Treatment 5		
Treatment 6		
Treatment 7		