FHT
COMPLEMENTARY • BEAUTY • SPORTS

Body massage
Consultation form

Personal details

Name: ______________________________

Address: ______________________________

______________ Postcode: ______________

Occupation: ______________________________

Doctor: ______________________________

Practice address: ______________________________

______________ Postcode: ______________

Telephone (day): ______________________________

Evening: ______________________________

Mobile: ______________________________

Email: ______________________________

Emergency contact: ______________________________

Telephone: ______________________________

GP practice tel: ______________________________

General state of health

Do you exercise regularly? O Yes O No

Are you taking any medication? O Yes O No

Are you on any special diet? O Yes O No

Do you smoke? O Yes __ per day O No

Do you drink alcohol? O Yes __ units per week O No

How would you describe your stress levels? O High O Med O Low

How would you describe your energy levels? O High O Med O Low

How would you describe your sleep pattern? ______________________________

What do you do for relaxation? ______________________________

Have you ever had a massage treatment? O Yes O No

Reason for treatment? ______________________________

Height: ______________________________

Weight: ______________________________

Date of Birth: ______________________________

Female clients only

Could you be pregnant? O Yes __ weeks O No

Are you breastfeeding? O Yes O No

Date of last period? ______________

Have you had an IUD fitted in the last 12 weeks?

O Yes O No

Conditions and/or symptoms

Question	Yes	No
Do you suffer from unstable blood pressure?	O Yes	O No
Do you suffer from any heart disorders?	O Yes	O No
Do you suffer from phlebitis?	O Yes	O No
Do you have a history of thrombosis/embolism?	O Yes	O No
Do you have epilepsy?	O Yes	O No
Do you have a dysfunction of the nervous system?	O Yes	O No
Do you suffer from any infectious diseases?	O Yes	O No
Do you suffer from any skin disorders?	O Yes	O No
Do you have any severe bruising?	O Yes	O No
Do you have any recent scar tissue?	O Yes	O No
Have you recently suffered from a haemorrhage?	O Yes	O No
Do you have any varicose veins?	O Yes	O No
Do you suffer from any swelling/oedema?	O Yes	O No
Do you have any recent cuts or abrasions?	O Yes	O No
Have you recently had any operations?	O Yes	O No
Have you recently had any inoculations?	O Yes	O No
Have you ever had or do you have cancer?	O Yes	O No
Do you have any recent fractures or sprains?	O Yes	O No
Are you currently suffering from a fever?	O Yes	O No
Do you have diabetes?	O Yes	O No
Do you have osteoporosis?	O Yes	O No
Do you suffer from arthritis?	O Yes	O No
Do you suffer from any back problems?	O Yes	O No
Do you suffer from any allergies?	O Yes	O No
Have you recently consumed alcohol?	O Yes	O No
Have you recently consumed a heavy meal?	O Yes	O No
Do you have any other medical condition?	O Yes	O No

Please give details if you answered yes to any of the previous questions:

Section for use by therapist GP consent required? O Yes O No Verbal consent obtained? O Yes* O No
Written consent obtained? (attach) O Yes* O No

*(client to sign and date declaration below)

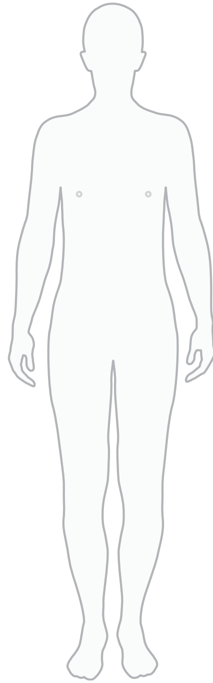
Client declaration: I declare the information that I have given is true and correct and that, as far as I am aware, I can undertake treatment with this establishment without any adverse effects. I have been fully informed about contra-indications and am willing, therefore, to proceed. I understand that body massage is not a substitute for medical advice and/or treatment.

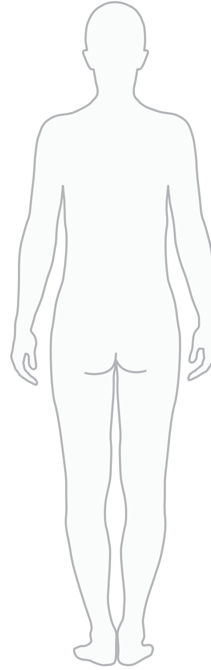
Client's signature: Date: Therapist's signature: Date:

Treatment Plan

Client Name: ____________________

FRONT VIEW





BACK VIEW

Date:	Reason for treatment:	Treatment aim:		Medium:
Comments and aftercare advice:				Client feedback:
Therapist signature:		Date:	Client signature:	
Date:	Reason for treatment:	Treatment aim:		Medium:
Comments and aftercare advice:				Client feedback:
Therapist signature:		Date:	Client signature:	
Date:	Reason for treatment:	Treatment aim:		Medium:
Comments and aftercare advice:				Client feedback:
Therapist signature:		Date:	Client signature:	
Date:	Reason for treatment:	Treatment aim:		Medium:
Comments and aftercare advice:				Client feedback:
Therapist signature:		Date:	Client signature:	

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