

**AMANDA MASSAGE**

Consultation Form

**Therapist Name:**

**Date:**

**Client Name:**

**Address:**

**Profession:**

**Tel. No:**

**PERSONAL DETAILS**

**Age group:** Under 20[ ]  20–30[ ]  30–40[ ]  40–50[ ]  50–60[ ]  60+[ ]

**Lifestyle:** Active**[ ]** Sedentary**[ ]**

**Last visit to the doctor:**

**GP address:**

**No. of children (if applicable):**

**Date of last period (if applicable):**

**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. Multiple sclerosis, Parkinson’s disease, Motor neurone disease) [ ]

Bell’s Palsy [ ]

Trapped/Pinched nerve (e.g. sciatica) [ ]

Inflamed nerve [ ]

Cancer [ ]

Postural deformities [ ]

Cervical spondylitis [ ]

Spastic conditions [ ]

Kidney infections [ ]

Whiplash [ ]

Slipped disc [ ]

Undiagnosed pain [ ]

When taking prescribed medication [ ]

Acute rheumatism [ ]

**CONTRAINDICTIONS 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 [ ]

Pregnancy (abdomen) [ ]

Cuts [ ]

Bruises [ ]

Abrasions [ ]

Scar tissue (2 years for major operation and 6 months for a small scar) [ ]

Sunburn [ ]

Hormonal implants [ ]

Menstruation (abdomen -first few days) [ ]

Haematoma [ ]

Hernia [ ]

Recent fractures (minimum 3 months) [ ]

Gastric ulcers [ ]

After a heavy meal [ ]

Conditions affecting the neck [ ]

**WRITTEN PERMISSION REQUIRED BY *(select if/where appropriate):***

GP/Specialist [ ]  Informed consent [ ]

Either of which should be attached to the treatment form.

**PERSONAL INFORMATION *(select if/where appropriate)*:**

**Muscular/Skeletal problems:** Back [ ]  Aches/Pain [ ]  Stiff joints [ ]  Headaches [ ]

**Digestive problems:** Constipation [ ]  Bloating [ ]  Liver/Gall bladder [ ]  Stomach [ ]

**Circulation:** Heart [ ]  Blood pressure [ ]  Fluid retention[ ]  Tired legs [ ]  Varicose veins [ ]

Cellulite [ ]  Kidney problems [ ]  Cold hands and feet [ ]

**Gynaecological:** Irregular periods [ ]  P.M.T [ ]  Menopause [ ]  H.R.T [ ]  Pill [ ]  Coill[ ]  Other

**Nervous system:** Migraine [ ]  Tension [ ]  Stress [ ]  Depression [ ]

**Immune system:** Prone to infections [ ]  Sore throats [ ]  Colds [ ]  Chest [ ]  Sinuses [ ]

**Regular antibiotic/medication taken?** Yes [ ]  No [ ]  If yes, which ones

**Herbal remedies taken?** Yes [ ]  No [ ]  If yes, which ones

**Ability to relax:** Good [ ]  Moderate [ ]  Poor [ ]

**Sleep patterns:** Good [ ]  Poor [ ]  Average No. of hours

**Do you see natural daylight in your workplace?** Yes [ ]  No[ ]

**Do you work at a computer?** Yes [ ]  No [ ]  If yes how many hours

**Do you eat regular meals?** Yes [ ]  No [ ]

**Do you eat in a hurry?** Yes [ ]  No [ ]

**Do you take any food/vitamin supplements?** Yes [ ]  No [ ]  If yes, which ones

**How many portions of each of these items does your diet contain per day?**

Fresh fruit: Fresh vegetables: Protein source?

Dairy produce: Sweet things: Added salt: Added sugar:

**How many units of these drinks do you consume per day?**

Tea: Coffee: Fruit juice: Water: Soft drinks: Others:

**Do you suffer from food allergies?** Yes [ ]  No [ ]

**Do you suffer from eating disorders?** Bingeing? Yes [ ]  No [ ]  Overeating? Yes [ ]  No [ ]

Under eating? Yes [ ]  No [ ]

**Do you smoke?** No [ ]  Yes [ ]  How many per day?

**Do you drink alcohol?** No [ ]  Yes[ ]  How many units per day?

**Do you exercise?** None [ ]  Occasional [ ]  Irregular [ ]  Regular [ ]  Types

**What is your skin type?** Dry[ ]  Oily [ ]  Combination[ ]  Mature [ ]  Young [ ]  Normal [ ]

**Do you suffer/have you suffered from:** Dermatitis[ ]  Acne [ ]  Eczema [ ]  Psoriasis [ ]

Allergies [ ]  Hay Fever [ ]  Asthma [ ]  Skin cancer [ ]

**Stress level:** 1–10 (10 being the highest)

At work: [ ]  At home: [ ]

**Reason for treatment:**

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**Treatment provided and how:**

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**Client feedback during and after the treatment:**

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**Additional home care advice:**

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**Client’s Signature**:

**Candidate’s Signature**: