

**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:** ActiveSedentary

**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**: