CONSULTATION FORM

Holistic Massage

Client Note:

The following information is required for your safety and to benefit your health. There are certain conditions, which may require special care. Please fill in or tick the box as appropriate.
The information given will be treated in the strictest of confidence.

Personal Details:

Title: …… Name ……..……

Address: ……..……...

..……...…… Postcode:……

No. of Children:…….…….…...…..…….…… Date of Birth: ….……

Profession: ……..……..Phone No: …….…….……

E-mail: ……..…….

GP name and address: ……..…….

Contraindications requiring medical permission: In circumstances where medical permission cannot be obtained client must give informed consent in writing prior to treatment.

Slipped disc □ Asthma □ Medical oedema □ Epilepsy □ Bell's Palsy □ Cancer □

Haemophilia □ Arthritis □ Kidney infections □ Whiplash □ Inflamed nerve □

Osteoporosis □ Diabetes □ Acute rheumatism □ Pregnancy □ Spastic condition □

Postural deformities □ Nervous/Psychotic conditions □ Trapped/Pinched nerve (e.g. sciatica) □

Cardio vascular conditions □ (thrombosis, phlebitis, high or low blood pressure, heart conditions)

Nervous system dysfunction □ (Muscular sclerosis, Parkinson's disease, Motor neurone disease)

Undiagnosed pain □ ……...

Recent operations □ ……..

Other condition being treated by GP or another complementary therapist:……...

Prescribed medication:……...

Localised Contraindications:

Localised swelling □ Inflammation □ Sunburn □ Varicose veins □ Hormonal implants □

Cervical spondylitis □ Haematoma □ Hernia □ Gastric ulcers □ Cuts/Bruises □

Recent fractures (minimum 3 months) □ Undiagnosed lump/bumps □

Skin diseases (Eczema, Acne, Dermatitis, Psoriasis, other) □ ……..

Scar tissues (2 years for major and 6 months for a small scar) □ ……..

Address: 5 Earlspark Crescent, Bieldside, Aberdeen, AB15 9AY
Website: www.ainetherapies.co.uk E-mail: info@ainetherapies.co.uk
Mobile: 07798 557454

Other details:

Muscular/Skeletal problems: Back □……..….. Stiff joints □…..……

Digestive problems: Constipation □ Bloating □ Stomach □ Liver/Gall bladder □

Circulation: Cold hands and feet □ Cellulite □ Tired legs □ Kidney problems □

Nervous system: Headaches □ Migraine □ Tension □ Stress □ Depression □

Immune system: Sore throat □ Sinuses □ Colds □ Chest □ Prone to infection □

Gynaecological: Menopause □ H.R.T □ P.M.T □ Pills □ Irregular periods □

Coil □ Other □ …… Date of last period: ……...……

Aids or STD: ……...…….

Current homeopathic, vitamins supplements, etc:……..……..……

How would you describe your diet? (Portions/cups a day)

Veg/Fruit…… Dairy Produce…… Sweet Things….. Protein cont. food…….…….

Tea……. Coffee……. Water……. Soft Drinks…….. Other…….

Eating in a hurry □ Regular meals □ Overeating □ Allergies □ ...……

Do you smoke? No □ Yes □ average per day: ……...……

Do you drink alcohol? No □ Yes □ average consumption daily/weekly: …..……..……

General state of health:

Stress levels: *home:* High □ Medium □ Low □ *work*: High □ Medium □ Low □

Sleep pattern: Good □ Average □ Poor □ Ability to relax: Good □ Average □ Poor □

Working at computer: No □ Yes □ (hours daily/weekly) ……..…

Hobbies/relaxation activities: ……

Have you had a Complementary Treatment before? No □ Yes □ (recently?)…..……..

Reason for seeking treatment: ……

Client declaration:

I declare that the information I have given is correct and that as far I am aware I can undertake treatment without any adverse effects. I do not suffer any contagious diseases (Diarrhoea, vomiting, etc.), which could spread to other clients coming to the clinic and I am not under the influence of recreational drugs or alcohol. I have been fully informed about the treatment and any contraindications and I am willing to proceed. I understand that any complementary therapy treatment does not substitute medical treatment. I agree that my data can be securely stored by A'INE Complementary Therapies, who will not share data with third parties without prior consent.

Client Signature: …….. Date: ……

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