

# MASSAGE CONSULTATION FORM

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Mobile: \_\_\_\_\_ Home Tel: \_\_\_\_\_ Work Tel: \_\_\_\_\_

Email \_\_\_\_\_

Profession: \_\_\_\_\_

How did you hear about our services?: \_\_\_\_\_

## **Please Circle**

Have you had a massage previously? Yes No  
Stress Level: Don't Stress Moderate High Very High  
Are there any areas of the body you would prefer your therapist to focus on?

Are there any areas where you prefer not to be massaged? \_\_\_\_\_

How do you prefer your massage pressure? Please Circle  
Soft Moderate Firm Very Firm

Which essential oil blend would you prefer? Please Circle  
Stress Relief Sleepy Vitality Energy Tranquillity

## **FEMALE DATA:**

Are you pregnant? Yes<sup>1</sup> No<sup>1</sup> Menopause Yes<sup>1</sup> No<sup>1</sup>

## **HEALTH:**

Are you currently receiving any medical treatment: \_\_\_\_\_ Yes<sup>1</sup> No<sup>1</sup>

If yes, what type? \_\_\_\_\_

Are you on any medication? If yes, what type? \_\_\_\_\_

Have you any injuries including spinal injuries? \_\_\_\_\_

Do you suffer from any of the following? If so please tick the box.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Breathing difficulties | <input type="checkbox"/> Liver Disease   |
| <input type="checkbox"/> Chest Pain              | <input type="checkbox"/> Asthma/Bronchitis      | <input type="checkbox"/> Hepatitis       |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> HIV/AIDS        |
| <input type="checkbox"/> Pregnant                | <input type="checkbox"/> Nausea                 | <input type="checkbox"/> Glandular Fever |
| <input type="checkbox"/> Poor Circulation        | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Varicose Veins          | <input type="checkbox"/> Migraines              | <input type="checkbox"/> Arthritis       |
| <input type="checkbox"/> Thrombosis/Clots        | <input type="checkbox"/> Recent Infections      | <input type="checkbox"/> Osteoporosis    |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Bone Fractures         | <input type="checkbox"/> Cancer          |
| <input type="checkbox"/> Epilepsy                |   |  |

Other Health Problems? Please state: \_\_\_\_\_

## **EMERGENCY CONTACTS:**

1. Name: \_\_\_\_\_ Mobile: \_\_\_\_\_

Work: \_\_\_\_\_ Home: \_\_\_\_\_

**Customer Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_