MASSAGE TREATMENT CONSULTATION

Please complete using CAPITAL LETTERS				**Date:**	
Name:				**Birthdate:**	
Address:					
Tel No:			**Email:**		
Occupation:					
GP Details:	**Name:**	**Surgery:**		**Tel No:**	

Please complete all questions, providing details where relevant

Question	No	Yes	Comments/details
Are you currently seeing a GP / Health PR actioner?			
Are you currently taking prescribed medication?			
Is there any chance you could be pregnant?			
Do you have any allergies?			
Have you consumed alcohol or recreational drugs in the last 12 hours?			
Are you currently suffering from a fever or illness?			
Do you suffer from diarrhoea or constipation?			
Have you been diagnosed with or have a history of:			
Epilepsy?			
Arthritis?			
Diabetes Type 1 or Type 2?			
Cancer (present or in the past)			
Heart or Lung Disease?			
High or Low Blood Pressure?			
Slipped Disks, Whiplash or Bone Damage?			
TB?			
Headaches / Migraines?			
Skin conditions- any, including bruising/scars etc.?			
Any other chronic/serious illnesses (presently or historically?)			
Have you had any recent or past operations/surgery?			
Is there anything else regarding your health that you feel may be relevant, not mentioned above?			

SPECIAL DIETRY REQUIREMENTS:	
WATER INTAKE PER DAY:	
EXERCISE PER WEEK:	
AREAS OF TIGHTNESS/TENSION	
CLIENTS SIGNATURE **To confirm details are true.**	
CONTRAINDICATIONS*: (Therapist to complete)*	None _____ Localised to: _____ Medical Approval Obtained _____

Client Declaration

I have completed a pre-treatment consultation and I confirm that through the information provided by the therapist, and answers to my questions, that I have full understanding of the treatment procedure and relevant contraindications. On the date of signing, I confirm that all the personal and medical information about myself and my current and historical health has been disclosed fully and correctly, and that I have not omitted any information concerning my health or state of wellbeing. I confirm that should my medical circumstances or health change in any way between treatments, I will inform my therapist prior to any subsequent treatments, and consequences resulting from the failure to do so is wholly my responsibility.

I confirm my understanding that there is a possibility of some physical discomfort for a short time during, and for short periods following treatments, as my body adjusts to the treatment being received.
I confirm and consent to the details of this consultation form being stored and used by Target Therapies to contact me regarding their services and accessed by all therapists working for Target Therapies.

I confirm my understanding that my therapist will not diagnose illness, disease or any other physical or mental disorder and that massage therapy is not a substitute for a qualified medical examination, diagnosis or treatment.
Should my therapist believe there to be a particular health issue or contraindication, I agree to obtain my GP/practitioner's consent for therapies to continue, and understand that it may be necessary to delay treatments with Target Therapies until this is achieved. In agreement with my medical professional, my therapist will then devise a treatment strategy around this diagnosis as appropriate.

I confirm that my participation in the treatment is undertaken freely and is my choice.
I hereby confirm that I fully understand and accept the contents of the Client Declaration.

Client's Name (block capitals)_____

Client's Signature_____

Date_____

By signing below, I hereby declare that I have accurately and honestly updated my therapist about any changes or developments of my health and current wellbeing prior to each therapy session:

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	Date	Therapy Type	Paid	Changes to health/wellbeing	Client Signature