profile

Client

Forename

Middle names

Surname

Sex

Date of Birth

D Mon YYYY

Height

Weight

Contact telephone

Alternate telephone

Emergency contact number

Address

Postcode

What is your current marital status?

Tick one ✓

Single **Married** **Separated**

Divorced **Widowed**

Number of children

Ages

Client's GP

GPs Name

Contact telephone

Address

Postcode

consultation

First Consultation

D Mon YYYY

Reason for treatment

Have you had massage therapy before?

Tick one ✓

☐ **No**

☐ **Yes**

What type? Why? Was it pleasant?

Are you receiving any other type of therapy?

Tick one ✓

☐ **No**

☐ **Yes**

What type? Why?

Is a release or consent form required to be signed?

Tick one ✓

☐ **No**

☐ **Yes**

Sent to whom	Date

Observations

consultation

Client's Medical History

Operations/surgery

Type	Mon YYYY	Details

Family medical history

Present health/medication

Do you regularly take anti-biotics?

Tick one ✓ ☐ **No** ☐ **Yes** _____

Please specify

consultation

Muscular/skeletal problems

Tick all that apply ✓

- ☐ Neck
- ☐ Back
- ☐ Rheumatism
- ☐ Aches/Pains
- ☐ Stiff joints
- ☐ Headaches

Digestive problems

Tick all that apply ✓

- ☐ Constipation
- ☐ Bloating
- ☐ Liver/gall bladder
- ☐ Stomach
- ☐ Intestinal

Circulation

Tick all that apply ✓

- ☐ Heart condition
- ☐ Fluid retention
- ☐ Cellulite
- ☐ Tired legs
- ☐ Varicose veins

Gynaecological

Tick all that apply ✓

- ☐ Irreg. Periods
- ☐ PMT
- ☐ Menopause
- ☐ HRT
- ☐ Pill
- ☐ Coil

Other

Is it possible that you may be pregnant?

Tick one ✓

- ☐ N/A
- ☐ No
- ☐ Yes ➔
- ☐ Months

Nervous system

Tick all that apply ✓

- ☐ Sensitive
- ☐ Migraine
- ☐ Tension
- ☐ Headaches
- ☐ Stress
- ☐ Clinical Depression

Immune system

Tick all that apply ✓

- ☐ Prone to infection
- ☐ Sore throats
- ☐ Colds
- ☐ Chest
- ☐ Sinuses
- ☐ HIV

consultation

Which of these do you or have you suffered from:

Tick all that apply ✓

☐	**High or low blood pressure**	
☐	**Diabetes**	
☐	**Heart condition**	
☐	**Varicose veins**	
☐	**Skin disorders**	
☐	**Allergies**	
☐	**Cancer**	
☐	**Epilepsy**	
☐	**Acute infectious diseases**	
☐	**Skin infections**	
☐	**Recent haemorrhage**	
☐	**Thrombosis**	
☐	**Recent scar tissue**	
☐	**Severe bruising/cuts**	
☐	**Undiagnosed lumps**	

Is there any other condition that you are aware of that may affect the proposed treatment?

Tick one ✓

☐ **No** ☐ **Yes**

Please specify

consultation

Profession

Activities undertaken in your work

Do you see daylight in your workplace?

Tick one ✓ ☐ **No** ☐ **Yes**

How easy is it for you to relax?

Tick one ✓ ☐ **Very easy** ☐ **Average** ☐ **Difficult**

Hobbies and creative interests

What best describes your sleep patterns?

Tick one ✓ ☐ **Good** ☐ **Average** ☐ **Poor**

How many hours sleep do you usually get?

Tick one ✓ ☐ **Hours per night**

Do you eat regular meals?

Tick one ✓ ☐ **No** ☐ **Yes**

Do you eat in a hurry?

Tick one ✓ ☐ **No** ☐ **Yes**

Do you take food or vitamin supplements?

Tick one ✓ ☐ **No** ☐ **Yes**

Would you consider your diet to be well balanced?

Tick one ✓ ☐ **No** ☐ **Yes**

consultation

For each of the following food types, how much is included in your daily diet?

Tick one ✓

Fresh fruit	☐	**A lot**	☐	**Average**	☐ **Very little**
Fresh vegetables	☐		☐		☐
Protein	☐		☐		☐
Dairy produce	☐		☐		☐
Sweet things	☐		☐		☐
Added salt	☐		☐		☐
Added sugar	☐		☐		☐
Tea	☐		☐		☐
Coffee	☐		☐		☐
Artificial stimulants	☐		☐		☐
Fruit juices	☐		☐		☐
Water	☐		☐		☐
Soft drinks	☐		☐		☐

Is your normal diet restricted in any way?

Tick all that apply ✓

	☐	**No**	☐	**Vegan**	☐ **Vegetarian**
	☐	**Wheat free**	☐	**Dairy free**	☐ **Kosher**
	☐	**Sugar free**	☐	**Low sodium**	☐ **Low fat**
		Other	☐		

Do you suffer from food allergies?

Tick one ✓ ☐ **No** ☐ **Yes**

Do you suffer from bingeing?

Tick one ✓ ☐ **No** ☐ **Yes**

Do you suffer from over-eating?

Tick one ✓ ☐ **No** ☐ **Yes**

Do you smoke tobacco?

Tick one ✓ ☐ **No** ☐ **Yes** ☐ **Per day**

Do you drink alcohol?

Tick one ✓ ☐ **No** ☐ **Rarely** ☐ **Weekends**

☐ **Daily** ☐ **Units per week**

consultation

Do you exercise?

Tick one ✓ ☐ **No** ☐ **Rarely** ☐ **Irregularly**

☐ **Regularly** ☐ **Hours per week**

If you exercise, what do you do?

Which of these best describes your general skin condition?

Tick one ✓ ☐ **Dry** ☐ **Oily** ☐ **Sensitive**

☐ **Damaged** ☐ **Combination** ☐ **Normal**

Do you suffer from acne?

Tick one ✓ ☐ **No** ☐ **Yes**

Do you suffer from dermatitis?

Tick one ✓ ☐ **No** ☐ **Yes**

Do you suffer from eczema?

Tick one ✓ ☐ **No** ☐ **Yes**

Do you suffer from psoriasis?

Tick one ✓ ☐ **No** ☐ **Yes**

Do you suffer from allergies?

Tick one ✓ ☐ **No** ☐ **Yes** Please specify

Do you suffer from hay fever/pollen allergy?

Tick one ✓ ☐ **No** ☐ **Yes**

Do you suffer from asthma?

Tick one ✓ ☐ **No** ☐ **Yes**

Please read carefully the following paragraph and then indicate your acknowledgement by signing below.

I understand that the information above provided by me is confidential and will only be used in relation to the treatment I will receive. I certify that, to the best of my knowledge, the information is correct at the current time. I understand that at any time such that this information changes I am obliged to notify the therapist prior to further treatment and that failure to do so absolves the therapist from any adverse effects that may arise as a result of non-disclosure. I have been fully informed of contra-indications to receiving therapy and understand that I am receiving treatment from a student massage therapist.

Date *Client's signature*