Perfect Circle Therapy

Mobile massage by Sarah

Consultation Form

Name: ……

D.O.B: ……

Tel no: ……

Address:…….
…….
……..
……..

Email: ……..

Medical questionnaire

Please read through the following list of conditions:

- Fever
- Contagious or infectious diseases, including colds and flu.
- Under the influence of alcohol or drugs, including prescription pain medication.
- Acute injuries.
- Neuritis.
- Skin diseases.
- Varicose veins
- Undiagnosed lumps or bumps
- Bruises, cuts or abrasions
- Sunburn
- Undiagnosed pain
- Inflammation, including arthritis
- Oedema
- Psoriasis or eczema
- High blood pressure
- Osteoporosis
- Cancer
- Nervous or psychotic conditions
- Heart problems, angina, those with pacemakers
- Epilepsy
- Diabetes
- Trapped or pinched nerves
- Cardio-vascular conditions (thrombosis, phlebitis, hypertension, heart conditions)
- Any condition already being treated by a medical practitioner.

Have you suffered from, or do you suffer from any of the above conditions? (If yes, please circle all that apply to you) Yes/No

Have you had surgery in the last 6 months? Yes/No

Are you currently taking any medication? Yes/No

Are you or have you recently been pregnant? Yes/No

Is there any other information that may affect your massage?
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……
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CThA
Complementary Therapists Association

Perfect Circle Therapy

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About your treatment

What is your reason for booking a massage? (Please circle all that apply to you)

- Relaxation
- To de-stress
- To relieve general tensions
- To focus on a particular area of tension
- Other

If other, please state:

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Any other comments?

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Please sign below to confirm that the information you have provided is correct, you have discussed any queries or relevant medical information with your therapist and that you are happy for your treatment to go ahead

Signed: …… Date: ……..