

Indian Head Massage Client Consultation Form

The following information is required for your safety & to benefit your health. All information will be treated in the strictest of confidence & will not be discussed or passed onto a third party.

Name: _____	Telephone Number: _____
Address: _____ email address _____	
Post Code _____	Date of Birth: _____

Do any of the following apply to you?	✓ yes
Fever	
Contagious or infectious diseases, including colds and flu.	
Under the influence of alcohol or drugs, including prescription pain medication	
Recent operations or acute injuries.	
Neuritis - inflammation of the peripheral nervous system	
Skin diseases	
Psoriasis or eczema	
Undiagnosed lumps or bumps	
Pregnancy.	
Bruising.	
Cuts or abrasions.	
Inflammation, including arthritis	
Undiagnosed pain.	
Cardio-vascular conditions (thrombosis, phlebitis, hypertension, heart conditions)	
Any condition already being treated by a medical practitioner.	
Oedema	
Epilepsy	
Psoriasis or eczema. - severe	
Diabetes.	
Bell's palsy / trapped or pinched nerves	
Osteoporosis.	
Cancer.	
Nervous or psychotic conditions	
Heart problems, angina, those with pacemakers	
Is there anything else the therapist should be made aware of?	
Details:	

Emergency Telephone No.

<u>Are you taking any regular medication?</u> Yes / No <u>Details of Medication</u> _____ _____ _____

If I had to call an ambulance is there anything they should know? Yes / No _____ _____ _____
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<p>Client declaration: I declare that the information I have given is correct and as far as I am aware I can undertake treatments without any adverse effect. I have been fully informed about any of the treatments contra-indications and contra-actions and I are therefore willing to proceed with treatment. I understand that the therapist holds no responsibility for any adverse reactions to this treatment or any subsequent treatments undertaken. I also understand that I am responsible for my own health, safety and well being.</p> <p>If GP referral was necessary, has your GP given consent for treatment Yes / No?</p> <p>Clients Signature</p> <p>Date:</p>

Total Contraindications – Treatments cannot proceed
Local Contraindications – avoid areas
Medical Contraindications – Written permission from GP needed