



Body Massage Consultation Form

Please take a moment to fill out the questionnaire below. Your answers will allow your therapist to target your specific conditions and provide you with a truly personalised experience.

Name _____
Date of Birth _____
Email _____
Telephone _____

Medical History

Hyper Sensitive Skin
Allergy (Please specify)
Glandular Fever / Chronic Fatigue
Lymphatic Cancer
Heart Disease
Circulatory Problems
Blood Pressure Abnormality
Epilepsy
Diabetes
Phlebitis / Varicose Veins
Neuropathy / Nerve Damage

Pregnancy
Skin diseases/disorders
Skin Cancer
Metal pins/plates
Migraines
Recent Injury
Recent Surgery (last 12 months)
If yes, please specify _____

Other (Please specify) _____

Are you currently under a physician's care? Yes No
If yes, please specify _____

Have you had any reactions to products? Yes No
If so, what sort? _____

In what areas of your body do you carry most of your stress and tension? _____

Are you currently taking any medication? Yes No
If yes, please specify _____

Declaration

I confirm that the above statements are true and correct and that Essential Therapie cannot accept liability for injury suffered because of incorrect or omitted information.

Signed _____

Date _____

