Body Massage Consultation Form

www.essential-therapie.co.uk

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

ESSENTIAL therapie

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Date	Therapist	Treatment Type / Comments