Naturally Chiropractic

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Massage consultation sheet

Name ..... Date of birth .....

Address .....

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Occupation ..... Is your job sedentary or active? .....

Telephone number ..... Mobile .....

Email ..... Preferred contact method? .....

Have you had a massage before? *yes* ☐ *no* ☐

Main areas of concern .....

What are your expectations from this treatment? .....

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How long have you had this problem? .....

Your health

Are you on blood pressure medication? *yes* ☐ *no* ☐ Is it? *high* ☐ *low* ☐

If so, for how long? .....

Do you suffer from regular headaches? *yes* ☐ *no* ☐

If yes, please describe what type of headache .....

Are you on any medication? *yes* ☐ *no* ☐

If yes, please give details .....

Are you currently being treated by your GP or another health professional for any condition? *yes* ☐ *no* ☐

If yes, please give details .....

Is there any chance you may be pregnant? *yes* ☐ *no* ☐

Our oil is nut based – do you have an allergy to nuts? *yes* ☐ *no* ☐ *If YES, don't worry, we have alternative oils.*

Have you had any surgery in the past 2 years? *yes* ☐ *no* ☐

If yes, please give details .....

Do you suffer from any of the below conditions or another complaint or condition not yet mentioned?

osteoarthritis	☐	rheumatoid arthritis	☐	osteoporosis	☐	eczema	☐
dermatitis	☐	psoriasis	☐	melanomas	☐	diabetes	☐
asthma	☐	heart disease	☐	varicose veins	☐	phlebitis	☐
epilepsy	☐	cancer					

If yes, please give details .....

Declaration

I confirm that the above statements are an accurate and true record of my current health status. I understand that this is not a medical treatment. I give my full consent to this treatment.

Client Signature ..... Date .....

Therapist Signature ..... Date .....

Massage Therapist, MFHT

Therapist's notes

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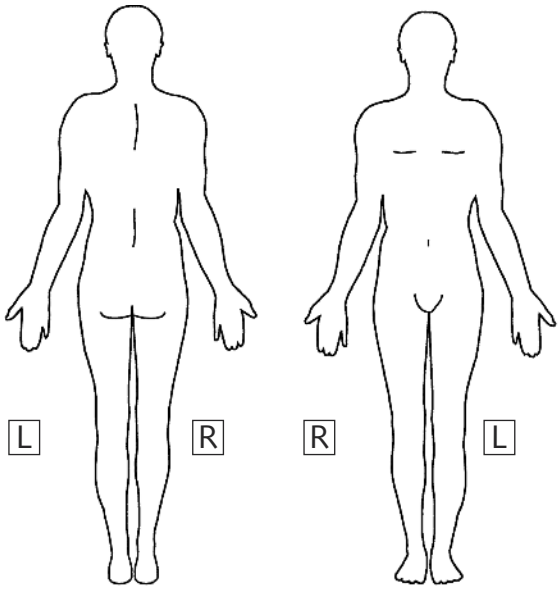
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