NUTRI-FIT

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Massage Consultation Form

The following information is required for your safety and to benefit your health. Although essential oils and massage are totally safe when administered professionally by a qualified therapist; there are certain contra-indications that require special attention.

The information that you give will be treated in the strictest confidence. It may, however, be necessary for you to contact your GP before any aromatherapy treatment can be given.

Date of Initial Consultation: _____ Client reference number: _____

General Client Information

Name: _____ D.O.B.: _____

Address: _____

_____

Tel: _____ Mob: _____ Email: _____

Client Medical Information

Name of Dr.: _____ Surgery: _____

Surgery Address: _____

_____

Surgery Tel: _____

Do you have or have you ever suffered from any of the following? (Please tick as appropriate)

Heart condition ☐ Thrombosis ☐ Abdominal complaint ☐
Recent operation ☐ Diabetes ☐ Circulatory disorder ☐
Skin disorder ☐ Epilepsy ☐ Varicose veins ☐
fracture or sprain ☐ A potentially fatal or terminal condition ☐
Dysfunction of the nervous system ☐ High or low blood pressure ☐
Recent haemorrhage or swelling ☐

Are you currently under GP/ Hospital care?

No ☐ Yes ☐ If yes, please give details below:
Treatment: _____
Medication (incl. dosages): _____

Female Clients

Is it possible that you may be pregnant? No ☐ Yes ☐

If pregnant, how many months are you? 0 - 3 mths ☐ 4 - 6 mths ☐ 7 - 9 mths ☐

Do you have any history of miscarriages? No ☐ Yes ☐

Dates of any pregnancies: _____

GP referral required? No ☐ Yes ☐

Clearance letter sent No ☐ Yes ☐ Date: _____

Clearance letter received No ☐ Yes ☐ Date: _____

Is your general health/immunity Good ☐ Average ☐ Poor ☐

Would you say your energy levels are High ☐ Average ☐ Low ☐

Would you consider your stress levels to be High ☐ Average ☐ Low ☐

How would you describe your Sleep pattern: Excellent sleep ☐ Restless ☐ Waking for bathroom ☐

Do you suffer from any of the following skin complaints? Allergies ☐ Dermatitis ☐ Eczema ☐ Psoriasis ☐ Dry skin ☐ Sensitive skin ☐ Other ☐

Do you suffer from any of the following circulation problems? Varicose veins ☐ Oedema ☐ Chillblains ☐ Heart problems ☐ Excessive cold/hot sweats ☐ Other ☐

Do you suffer from any of the following respiratory problems? Asthma ☐ Breathing difficulties ☐ Bronchitis ☐ Throat infections ☐ Sinusitis ☐ Colds ☐ Flu ☐ Other ☐

Do you suffer from any of the following digestive problems? Constipation ☐ Indigestion ☐ Colitis ☐ Candida ☐ Heartburn ☐ Acidity ☐ Flatulence ☐ Other ☐

Do you suffer from any of the following urinary problems? Cystitis ☐ Thrush ☐ Fluid retention ☐ Problems with urination ☐ Kidney disease ☐ Other ☐

Do you suffer from any of the following nervous/endocrine/ stress related problems? Anxiety ☐ Depression ☐ Headaches/migraines ☐ Insomnia ☐ Nervous tension ☐ Mood swings ☐ High/low energy levels ☐ Other ☐

Do you suffer from female health issues? Premenstrual tension ☐ Menopausal problems ☐ Problems with periods ☐ Other fertility problems ☐

In order of priority, please list particular issues that you would like treated during the sessions.
Issue 1: _____
Issue 2: _____
Issue 3: _____

Please give details of your typical daily diet:
Breakfast: _____ Lunch: _____
Dinner: _____ Snacks: _____
Supplements: _____ Fluid intake: _____

Weekly alcohol intake (units): < 5 ☐ 6 - 12 ☐ 13 > ☐

Do you smoke? No ☐ Yes ☐ _____ per day

Type of exercise taken (and how frequently?): _____

Any hobbies? Do you relax regularly, if so how?: _____

Have you tried aromatherapy or any other complementary therapies before?: _____

Are you currently having any complementary treatment? _____

(This can be done at the beginning of the consultation)

I declare that the information I have given is correct and as far as I am aware I can undertake treatment with this establishment without any adverse effects. I have been fully informed about contra-indications and I am willing to proceed with the treatment.

Client signature: _____ Date: _____

Therapist's signature: _____ Date: _____