



Confidential Client Record Form

PERSONAL DETAILS		DATE
NAME:		Date of Birth:
Address:		Age:
		Marital Status:
		Sex:
Postcode:		Height:
PHONE (HOME):		Weight:
PHONE (MOBILE):		Profession:
EMAIL:	@	No & age of Children:
GP's Address:		GP Name:

Conditions which may require a GP referral are capitalised below.

Completed record forms will be assessed before treatment. The Therapist reserves the right not to treat the client.

MEDICAL DETAILS / HISTORY	Yes	Details
Do you have any genetic / hereditary illness?		
Present State of Health		
CANCER?		
UNDIAGNOSED LUMPS		
Contagious Disease?		
Are you on any medication?		
Muscular / Skeletal:		
OSTEOARTHRITIS - POROSIS		
RHEUMATOID ARTHRITIS		
POSTURAL DEFORMITIES		
WHIPLASH/SLIPPED DISC		
Recent operations? 2yrs – 6mths		
Recent fractures? (3 months)		
Headaches		
Muscular Aches (see chart)		
Circulation:		
HEART PROBLEMS		
THROMBOSIS		
KIDNEY PROBLEMS		
HAEMOPHILIA		
DIABETES		
High / Low Blood Pressure		
Fluid Retention		
Varicose Veins		
Bad Circulation - cold hands/feet		

	Yes	Details
Allergies: Food (incl NUTS) ASTHMA Other		
Immune System: Prone to Infections Sore Throats / Regular Colds		
Gynaecological: Are you PREGNANT Irregular Periods Menopause Pill / hormonal implants		How many weeks
Nervous System: EPILEPSY MS ME MOTOR NEURONE DISEASE PARKINSONS DISEASE BELLS PALSY TRAPPED/INFLAMED NERVE Migraines Depression Stress		
Skin: Conditions-cuts, bruises, burns Melanomas Verucas or warts		Dry / Normal / Oily
Digestion: Irritable Bowel Syndrome Ulcers Other		
Please give details of any other problems that may be relevant.		

LIFESTYLE	
Exercise	Regular / Occasional [delete if n/a]
Type of Exercise	
Your Sleep Pattern	Good / Poor How many hours?
Ability to relax	Easy / Average / With difficulty

Disclaimer

Please read carefully and only sign if you are in full agreement with its contents, & that the medical history is true.

I _____ confirm that I have understood the treatment that I am to receive & confirm that I am willing to proceed without confirmation from my own GP or Consultant.

Or I _____ confirm that I have understood the treatment and given my medical history I would prefer to consult with my GP or Consultant prior to receiving the treatment. It is not the responsibility of your therapist to consult your GP or Consultant.

You should note that if the therapist is unable to explain to you the contra indications or is unsure of anything that may apply to a specific condition then they should not treat you without asking you to consult with your GP or Consultant.

I hereby indemnify the therapist against any adverse reaction sustained as a result of the treatment

I understand that Massages which are cancelled less than 24 hours of their appointment will be charged in full.

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

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