CONSULTATION FORM

Date	
Surname	
First Name	
Address	
Telephone	
Email Address	
Date of Birth	
Occupation	
GP Name & Address	
Medical & Surgical	
History	
Allergies	
Reason for Massage/	
Problem Areas	
Date Problem began	
Problem Frequency	
Headaches/Migraines	
Are you pregnant?	

General Health

	Very Good	Good	Fair	Poor
Appetite				
Relaxation				
Hearing				
Vision				
Sleep				

Hobbies/Interests	
Exercise/Sports	

I agree that I have not withheld any information about my current state of health and that I consider myself fit to receive a massage treatment. The above information is correct to the best of my knowledge. I will notify the therapist of any future changes in my general health before receiving further treatments.

Print Name	
Signature	