life CHIROPRACTIC CLINICS

CONSULTATION FORM - MASSAGE

Please fill out your details below prior to your treatment.

PERSONAL DETAILS:

Surname: ..... Forename(s): ..... DOB: ..... Age: .....

Address & Postcode: .....

Home Tel: ..... Mobile: ..... Work Tel: .....

Email: .....

GP Name & Practice: .....

Partner's Name: ..... No. & Age of Children: ..... Marital Status: S M D W

Occupation: ..... Who referred you to us: .....

Your motivation for visiting us today: .....

YOUR GENERAL HEALTH:

How would you describe your stress levels? ○ High ○ Medium ○ Low

How would you describe your energy levels? ○ High ○ Medium ○ Low

Do you exercise regularly? ○ Yes ○ No If yes how many times per week .....

Are you currently taking any medication? ○ Yes ○ No If yes which medication .....

Are you on a special diet? ○ Yes ○ No If yes which diet .....

Are you or could you be pregnant? ○ Yes ○ No

Are you wearing contact lenses or a hearing aid? ○ Yes ○ No

Have you ever had massage treatment before? ○ Yes ○ No

Have you ever had chiropractic treatment before? ○ Yes ○ No

Have you ever had a diagnostic X-Ray? ○ Yes ○ No

DO YOU OR HAVE YOU EVER SUFFERED WITH:

Please complete this section to the best of your knowledge as it will help plan a safe and effective massage session for you.

- ○ High Blood Pressure
- ○ Heart Disorders
- ○ Heart Conditions
- ○ Thrombosis / Embolism
- ○ Skin Disorders
- ○ Allergies / Sensitivity
- ○ Recent Haemorrhage
- ○ Back Pain / Problems
- ○ Swelling / Oedema
- ○ Osteoporosis
- ○ Epilepsy
- ○ Diabetes
- ○ Cancer
- ○ Arthritis
- ○ Bruise easily
- ○ Recent Accident / Injury
- ○ Recent Surgery
- ○ Artificial Joints / Limbs
- ○ Varicose Veins
- ○ DVT / Blood Clots
- ○ Fibromyalgia
- ○ Carpal Tunnel Syndrome

Please give further details to any anything you answered yes to: .....

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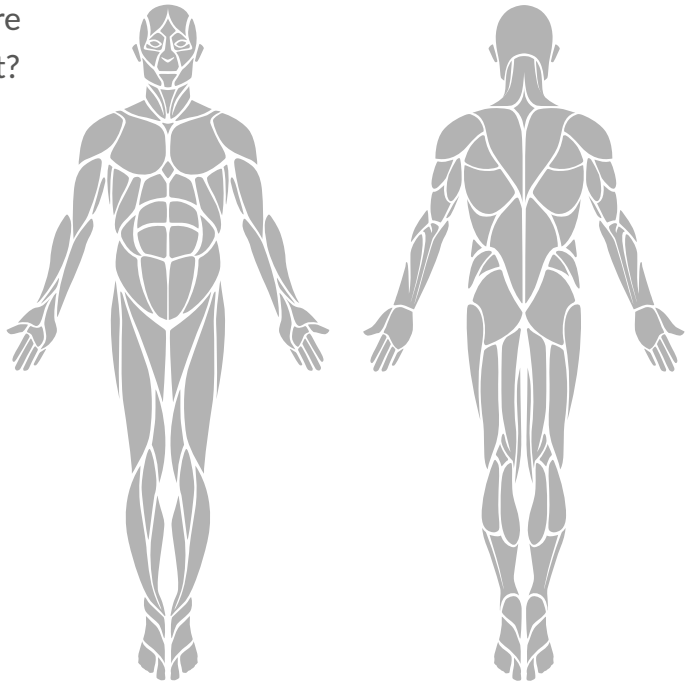
Are there any particular areas of the body where you are experiencing tension, stiffness pain or other discomfort?
○ Yes ○ No If yes please indicate in the diagram:



Do you have any particular goals in mind for this massage session? ○ Yes ○ No

If yes please explain .....

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YOUR CONSENT

I declare that the information that I have given is true and accurate and that, as far as I am aware, I can undertake treatment without any adverse effects and I am willing, therefore to proceed. I understand my personal data will be recorded and kept on file.

Signed: ..... Date: .....