Joanna Edwards. Massage Therapy. Client Consultation Form

Client Details

Name _____ DOB_____ Phone_____

Address_____ Email_____

Occupation _____ Emergency Contact _____ Tel _____

Medical History.

Do you have or have you had any of the following? Please tick all that apply to you:

□ Injuries, Fractures	□ Contagious Illness eg cold, flu, covid-19	Notes:
□ Whiplash	□ High or Low Blood Pressure	
□ Surgery/Surgical Procedure	□ Cardiac (Heart) problems, Pacemaker	
□ Metal pins/plates	□ Vaccination/Injection within the last 24h	
□ Pain, Swelling(s)	□ Skin Conditions, Bruises, Open wounds	
□ Hypermobility	□ Asthma, or other Respiratory problem(s)	
□ Hernia(s)	□ Circulation disorder	
□ Cancer	□ Deep Vein Thrombosis, Varicose Veins	
□ Pregnant	□ Digestive, Bowel or Bladder issues	
□ Diabetes Type I or II	□ Arthritis (Rheumatoid or Osteoarthritis)	
□ Epilepsy	□ Ankylosing Spondylitis	
□ Hemophilia	□ Myositis Ossificans	
□ Unexplained Weight Loss	□ Osteoporosis, Osteopenia	
□ Allergies	□ Other_____	

Current Medications

_____

_____

INDEMNITY:

I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, but is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion and improve a sense of wellbeing.

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any relevant information. If I experience any pain or discomfort during the session, I will immediately communicate that to the therapist so the treatment can be adjusted.

I consent to Joanna Edwards as a massage therapist taking my medical history to holding my personal information as determined by the General Data Protection Regulation policy for 5 years.

I confirm to the best of my knowledge that I have not withheld any information relevant to my treatment and that I understand and accept full responsibility for the treatment that I am given. I also agree that I have given the correct information as detailed on this form. I agree to inform the therapist should these circumstances change.

Client signature: _____Date: _____

Therapist signature: _____Date: _____