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*I'm a registered therapist, so you know I'm qualified and insured.*

**Client consultation form**

Date:

Client name	
Telephone number	
Email address	
Address	
Occupation	
Date of birth	
Doctors name, address and telephone number	

Please review the list below and cross any that apply to you.

Cardiac conditions	Haemorrhage or swelling	
High blood pressure	Warts	
Low blood pressure	Moles	
History of thrombosis /Embolism / stroke	Scar tissue	
Epilepsy	Pregnant	
Diabetes	Recent operation/fracture/broken bones or sprain	
Nervous System Dysfunction	Temperature / Fever on day of treatment	
Bruising / Cuts / abrasions	Cancer	
Varicose veins	Kidney problems	
Fibromyalgia	Allergies/ Sensitive skin	
Infectious diseases	Fungal infection	
Sunburn	Digestive issues (e.g. IBS, constipation, etc.)	
Inflamed joints	Acute joint disease / arthritis / gout	
Postural deformities	Damaged muscles	
History of headaches / migraines	Anxiety / Depression	
Osteoporosis		

Please advise below of any other health issue or recent illness not listed above.


Please advise below of any medication you are taking.


**Please complete the following life style questions.**

Please confirm if you do any of the following things, and how much.

Smoke	
Drink	
Exercise	

Please advise how well you are currently sleeping.


Please rate your current energy and stress levels (1-low to 10-high)

Your current energy levels are	
Your current levels of stress are	

What do you do to relax?


Are there any particular areas of tension in your body?


**Therapist to complete:**

Treatment to be undertaken	
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**Client declaration:**

I confirm that all the details I have given on my medical wellbeing are stated and accurate to my knowledge and that I will inform my therapist if any of these details should change. I consent to the treatment listed on this form. Massage should not be used instead of conventional care and you should always consult your GP or health professional for medical attention and advise.

<b>Client signature</b>		<b>Date:</b>	
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