Consultation Form

Indian Head Massage

Personal Details

Name:

Client No.:

Address:

Telephone (including code)

Postcode:

Day:

Occupation:

Evening:

Doctor:

Mobile:

Practice Address:

Postcode:

Practice:

General State of Health

Do you exercise regularly? no yes

Are you taking any medication? no yes

Are you on any special diet? no yes

Height:

Weight:

How would you describe your stress levels? high medium low

How would you describe your energy levels? high medium low

Date of birth:

Do you smoke? no yes, cigarettes per day

Do you drink alcohol? no yes, units per week

How would you describe your sleep patterns?

What do you do for relaxation?

Have you ever had an indian head massage treatment? no yes

Reason for treatment?

Female clients:

Could you be pregnant?

no yes, months

Conditions and/or Symptoms

Do you suffer from any of the following conditions?

Anxiety/stress? no yes

Depression? no yes

Sleeping problems? no yes

Headaches/migraines? no yes

Neck/shoulder strain? no yes

Eye strain? no yes

Sinus problems? no yes

Tinnitus? no yes

TMJ disorder? no yes

Dandruff? no yes

Hair loss? no yes

Premature greying? no yes

Psoriasis/eczema? no yes

Are you suffering from any infectious diseases or disorders? no yes

Do you have or have you recently had a heavy cold or fever? no yes

Have you suffered any recent head or neck injuries? no yes

Have you had a recent operation or have scar tissue to be aware of? no yes

Do you have any cysts or lumps? no yes

Do you suffer from unstable blood pressure? no yes

Do you suffer from any heart disorders? no yes

Do you have epilepsy? no yes

Do you have diabetes? no yes

Do you have any dysfunctions of the nervous system? no yes

Do you suffer from any skin disorders? no yes

Do you have any severe bruising? no yes

Do you have any recent cuts or abrasions? no yes

Have you recently had any operations? no yes

Do you suffer from any allergies? no yes

Have you recently consumed alcohol? no yes

Please give details if answered yes to any of the previous questions.