Consultation - strictly private and confidential.

In order for me to carry out the safest and most beneficial treatment for you, it is necessary to ask the following questions. Please read carefully and answer all the questions. Please tick either no or yes where necessary. Do you have or are you currently affected by any of these conditions?

	NO	YES
Any form of infection, disease or fever	☐	☐
Diarrhoea or vomiting	☐	☐
Under the influence of recreational drugs or alcohol	☐	☐
For women – are you on first 3 months of pregnancy	☐	☐

	YES
Diabetes	☐
High blood pressure	☐
Low blood pressure	☐
Varicose veins	☐
Depressed immune system	☐
Eczema	☐
Heart conditions	☐
Blood conditions	☐
Cancer	☐
Osteoporosis	☐
Undiagnosed pain	☐
Thrombosis/embolism	☐
Skin disorders	☐
Recent scar tissue	☐
Swelling/ oedema	☐
Any back problems	☐
Allergies	☐

	YES
Asthma	☐
Trapped/pinched nerve	☐
Epilepsy	☐
Cardiac patient	☐
Medication affected by heat	☐
Shingles	☐
Nervous system dysfunction	☐
Whiplash	☐
Acute rheumatism	☐
Arthritis	☐
Severe bruising	☐
Anxiety/depression	☐
Recent fractures or sprains	☐
Recent haemorrhage	☐
Recent cuts or abrasions	☐
Recent inoculations/vaccination	☐
Recent operations	☐

Please give details if answered ticked any of the above conditions or you have other medical conditions:

Any other diagnosed condition being treated by a GP or other complementary practitioner:

Are you receiving any other form of complementary therapy?

Client Declaration: I declare that the information that I have given is true and correct and that, as far as I am aware, I can undertake treatment with this establishments without any adverse effects. I have been fully informed about contra-indications and am willing, therefore, to proceed. I understand that aromatherapy massage therapy is not a substitute for medical advice and/or treatment.

Client's signature: Date:

Therapist's signature: Date:

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