WILLOW TREE
MASSAGE

Consultation Form

Name:

Email Address:

Telephone Number:

Date of Birth:	Gender:	Profession:

Medical Background:

Please state your reason for booking a massage treatment:	

Any medical conditions your therapist needs to be aware of:	

Are you currently taking any prescribed medication:	

Have you ever undergone an operation or plan to have any surgery or medical tests:	

Contraindications

Do you, or have you, ever suffered from any of the following:

Cellulitis	Contagious diseases	Thrombosis / DVT
Phlebitis	Severe undiagnosed headaches	Aneurysm
Stroke	Undiagnosed illness	Gangrene
Haemophilia	Varicose veins	Inflammatory conditions
Arthritis	Headaches	Migraines
Diabetes	Sunburn	Cancer
Anxiety	Uncontrolled high b/p	Depression
Severe numbness	Recent scar tissue	Heart condition
HIV/Aids	Unstable/replaced joints	Hepatitis
Epilepsy	Severe undiagnosed pain	Bone fractures
Sprains	Nervous system conditions	Severe bruising
Allergies	Muscular spasms	IBS
Fever	Oedema	Skin disorders / Any cuts
Asthma	Any injuries	Osteoporosis

Aches and Pains

Back Neck Shoulders Knee Stiff joints

Pain rating out of 10 (10 being the worst)

Females

Are you pregnant: Yes/ No

If yes, how many months:

Do you have a contraceptive implant: Yes/ No

Stress

How would you rate your stress levels on a scale of 1-10 (10 being the worst)

Sleep

How many hours sleep do you get on average:

Do you feel tired during the day: Yes/ No