ME TIME
treatments

Client Consultation Form

Name: ………………………………………………………………….	Address: …………………………………………………………………. …………………………………………………………………. ………………………………………………………………….	
Date of birth: ………………………………………………………………….		
Telephone Number: ………………………………………………………………….		
Email address: ………………………………………………………………….	Occupation: ………………………………	GP Name /Surgery ……………………………………

Do you suffer from any of the following? Please tick if any apply:

- ❑ Fever /Infection
- ❑ Blood condition (haemophilia, DVT, Hepatitis)
- ❑ Rheumatism/ Arthritis
- ❑ Osteoporosis / Cervical spondylitis
- ❑ Medical Oedema
- ❑ Nervous or psychotic condition
- ❑ Cancer
- ❑ Diabetes
- ❑ Hernia
- ❑ Epilepsy
- ❑ Asthma
- ❑ Heart Condition
- ❑ Autoimmune condition
- ❑ Other, please give detail(s) …………………………………………………………………………………………
……

Are you pregnant? Yes / No If yes, how many weeks…………….	Current state of health: Excellent……Good……..Fine…….Poor………
Please state any allergies or intolerances: ………………………………………………………………….	Current medication, or condition currently being treated by GP ……………………………………………………………………………

Major illnesses / accidents:
………

If you have any of the conditions listed above, please read the following carefully and only sign if you are in full agreement.

I confirm that I understand the massage treatment and that I am willing to proceed without confirmation from my GP or Consultant. I hereby indemnify the therapist against any adverse reaction sustained as a result of treatment.

or

I confirm that I understand the massage treatment and that I have consulted my GP or Consultant and gained his/her consent prior to proceeding.

***(delete as appropriate)**

Signed:……………………………………………………………… Date: ……………………………………………………….