Pure-Therapy

Complementary Therapies
Holistic Massage & Reiki

Pre Treatment – Medical & Lifestyle Questionnaire

Client Name					
Address					
Profession					
Tel no	Day		Eve		
	Mobile				
Email					
Age					
Please place an X in the relevant box i.e. Active X					
Lifestyle	Active		Sedentary		
Date of Last visit to Doctor		**GP Address**			
No. of children (if applicable)					
Why do you want to have a massage? **i.e. for health reasons, for relaxation, as a treat, to reduce the impact of stress, to help sleep patterns, etc.** **Please provide some guidance on what you are aiming to achieve from this therapy.**					

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CONTRA-INDICATIONS REQUIRING MEDICAL PERMISSION – or completion of disclaimer giving informed consent – see separate form on page 5 - in event medical permission cannot be obtained prior to treatment. Please place an X against any relevant conditions.			
Pregnancy		Haemophilia	
Medical oedema		Postural Deformities	
Epilepsy		Nervous/Psychotic conditions	
When taking prescribed medication		Trapped/Pinched Nerve (e.g. sciatica)	
Inflamed nerve		Slipped disc	
Cancer		Cervical spondylitis	
Whiplash		Kidney Infections	
Diabetes		Bell's Palsy	
Asthma		Spastic conditions	
Acute rheumatism		Kidney infections	
Arthritis		Undiagnosed pain	
Osteoporosis		Recent Operations	
Any condition already being treated by a GP or another complementary practitioner		Cardio vascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)	
		Any dysfunction of the nervous system (e.g. multiple sclerosis, Parkinson's disease, motor neurone disease	
CONTRA-INDICATIONS THAT RESTRICT TREATMENT or completion of disclaimer giving informed consent – see separate form on page 5 - in event medical permission cannot be obtained prior to treatment. Please place an X against any relevant conditions.			
Fever		Contagious or infectious diseases	
Skin Diseases		Under influence of alcohol	
Localised swelling		Diarrhoea or vomiting	
Inflammation		Undiagnosed lumps and bumps	
Varicose veins		Abrasions	
Pregnancy (abdomen) or recent delivery		Scar tissue (2 years for major operation and 6 months for a small scar)	
Cuts		Sunburn	
Bruises		Hormonal implants	
Hernia		Menstruation (abdomen – fist few days)	
Gastric ulcers		Recent fractures (minimum 3 months)	
After a heavy meal		Conditions affecting the neck	
WRITTEN PERMISSION REQUIRED BY (select if/where appropriate):			

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GP/Specialist		Informed consent	

PERSONAL INFORMATION (select if/where appropriate – place an X in the box):

Muscular/Skeletal problems:	Back		Aches/Pains		Stiff Joints		Headaches	
Digestive Problems:	Constipation		Bloating		Liver/ Gall Bladder		Stomach	
Circulation:	Heart		Blood Pressure		Fluid Retention		Tired Legs	
	Varicose Veins		Cellulite		Kidney Problems		Cold Hands and Feet	
Gynaecological:	Irregular Periods		PMT		Menopause		HRT	
	Pill		Coil		Other			
Nervous System:	Migraine		Tension		Stress		Depression	
Immune System:	Prone to Infections		Sore Throats		Colds		Chest	
	Sinuses							
Regular Antibiotic/ Medication Taken?	Yes		No		If yes, which ones?			
Herbal Remedies Taken?	Yes		No		If yes, which ones?			
Ability to relax:	Good		Moderate		Poor			
Sleep Patterns:	Good		Poor		Average No. of hours?			
Do you see natural daylight in your workplace?					Yes		No	
Do you work at a computer?			Yes		No		No. of hrs?	
Do you eat regular meals?			Yes		No			
Do you eat in a hurry?			Yes		No			
Do you take any food/vitamin Supplements?	Yes		No		If yes which ones?			
How many portions of each of these items does your diet contain per day?								
	Fresh Fruit		Fresh Vegetables		Protein? and source of protein			
	Dairy Produce		Sweet Things		Added Salt		Added Sugar	
How many units of these drinks do you consume per day?								
	Tea		Coffee		Fruit Juice		Water	
	Soft drinks		Others					
Do you suffer from food allergies?			Yes		No			
Do you suffer from eating disorders?			Bingeing?		Overeating?		Undereating?	
Do you smoke?	No		Yes		How many per day?			
Do you drink alcohol?	No		Yes		How many units per day?*			
Do you exercise?	None		Occasional		Irregular			
Type of exercise								

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What is your skin type?	Dry		Oily		Combination		Mature	
	Young							
Do you suffer / have you suffered from:	Dermatitus		Acne		Eczema		Psoriasis	
	Allergies		Hay Fever		Asthma		Skin Cancer	
Stress Level:	1-10 (10 being highest)				At work		At Home	

Alcohol levels – recommended maximum intake daily:

- Men – 3 to 4 units per day
- Women – 2 to 3 units per day

For example – a 175ml glass of 12% white wine is 2.1 units.
a 125ml glass of 12% champagne is 1.5 units.
a 250 ml glass of 13% red wine is 3.25 units.
a 330 ml bottle of lager (Becks – 5%) is 1.65 units
a pint of bitter (Old Speckled Hen – 4.5%) – 2.65 units

See - www.drinkaware.co.uk

Client Signature…… Date……

Therapist Signature…… Date……

Disclaimer

Client Information – Please read this carefully and only sign if you are in full agreement with its contents.

I, confirm that I have understood the treatment that I am to receive and confirm that I am willing to proceed without confirmation from my own GP or Consultant.

I acknowledge and understand if the therapist is unsure or unable to explain the contra indications that may apply to a specific condition then they should not treat me without asking me to consult with my GP or Consultant.

It is my responsibility and not that of the therapist to consult my Gp or Consultant. I hereby indemnify the therapist against any adverse reaction sustained as a result of the treatment.

Client Signature…… Date……

Therapist Signature…… Date……