Strictly Private & Confidential
Indian Head Massage Consent Form

PERSONAL DETAILS

The information you provide on this form is confidential. Information is not shared with any third parties. Information is used to help give you the best result from your treatment. Please complete fully and be as accurate as possible.

Name: **Date of Birth:** **Address:** **Contact No:** **Email:**	**Date:** **Occupation:** **Doctor's Name:** **Address:** **Contact No:**
How did you hear about us?	

In order to carry out the safest and most beneficial treatment, it is necessary to ask the following questions. Please read carefully and answer all questions.

Medical Checklist:

Primary health concern/problem:

Do you currently suffer from or have suffered from any of the following recently (in the last 6 months)? Please √

Allergies		Nervous system disorders		Vomiting/Diarrhoea	
Arthritis		Heart/circulatory problems		Joint/bone problems	
Asthma		Hypersensitivity		Osteoporosis	
Bruising/swelling		Pregnancy		Trapped nerve	
Cuts/abrasions		High/low blood pressure		Headaches/migraines	
Diabetes		Metal plates/pins		Weight problems	
Epilepsy		Pacemaker		Thrombosis/Embolism	
Skin diseases/disorders		Broken bones		Undiagnosed pain	
Varicose veins		Hernia		Kidney infections	
Gastric ulcers		Whiplash		Rheumatoid Arthritis	
Slipped/prolapsed disc		Any form of infection		Scar tissue less than 2 years	
Cancer		Dietary disorder		Scar tissue less than 6 months	
Recent head/neck injury		Fainting		Fever	

If any boxes are '√' please give details here

Medical History – any significant illness or operations

Current medication/supplements

Are you receiving any other complementary/alternative therapy or treatment from another medical practitioner?

Admin use only:

Is GP referral/consent necessary? ☐ Yes ☐ No

Please be aware that your GP may not agree to referral/consent for treatment and therefore treatment will not be possible.

Disclaimer: For our records, please confirm that you have read, understood and answered all the questions. If there is anything you do not understand, please ask. Otherwise, please read the following and sign below.

To the best of my knowledge, the information I have given is true and I have not withheld any information concerning my health. I will keep my therapist updated on my health should there be any changes to the answers given. I understand that there is a possibility I may experience some minor reactions as my body adjusts to treatment.

I understand that my therapist does not diagnose illness, disease or any other physical or mental condition. I understand that this treatment is not a substitute for medical examination, diagnosis or treatment. Whilst I recognise that all due care will be taken by the therapist, I am aware that my participation in the treatment is voluntary.

Signature of Client: Date:

Signature of Therapist: Date: