Consultation Form	Relax in Exeter

Personal Details

Title:		Name:			
Address:					
				Postcode:	
Tel. No.		Mobile No.			
Email:				Age:	
Occupation:					
Doctor:					
Practice Address:					

State of Health

Do you smoke?	❑ No ❑ Yes _____ cigarettes per day
Do you drink alcohol?	❑ No ❑ Yes _____ units per week
Any muscular/skeletal problems?	❑ No ❑ Yes Located _____
Any digestive problems?	❑ No ❑ Yes Located _____
Any circulation problems?	❑ No ❑ Yes Located _____
How would you describe your stress levels?	❑ High ❑ Medium ❑ Low
How would you describe your energy levels?	❑ High ❑ Medium ❑ Low
How often do you exercise?	❑ Never ❑ Occasionally ❑ Regularly
Are you on any regular medication?	❑ No ❑ Yes Specify _____
How would you describe your sleep pattern?	❑ Good ❑ Poor _____ No. of hours
Do you suffer from any allergies?	❑ No ❑ Yes Specify _____
Do you eat a healthy diet?	❑ No ❑ Yes
Do you drink tea/coffee?	❑ No ❑ Yes _____ cups per day
Do you work at a computer?	❑ No ❑ Yes _____ No. of hours
FEMALE ONLY – Could you be pregnant?	❑ No ❑ Yes

Conditions/Symptoms					
Fever		❑ No ❑ Yes	Recently consumed alcohol		❑ No ❑ Yes
Contagious/Infectious Disease		❑ No ❑ Yes	Any diarrhoea or vomiting		❑ No ❑ Yes
Localised swelling or inflammation		❑ No ❑ Yes	Undiagnosed lumps or bumps		❑ No ❑ Yes
Skin diseases		❑ No ❑ Yes	Varicose veins		❑ No ❑ Yes
Neck condition		❑ No ❑ Yes	Cuts, bruises, abrasions		❑ No ❑ Yes
Sunburn		❑ No ❑ Yes	Hormonal implants		❑ No ❑ Yes
Haematoma		❑ No ❑ Yes	Hernia		❑ No ❑ Yes
Recent Fracture		❑ No ❑ Yes	Gastric Ulcers		❑ No ❑ Yes
Scar tissue		❑ No ❑ Yes	Recent heavy meal		❑ No ❑ Yes
Pregnancy	❑ No ❑ Yes	**Whiplash**	❑ No ❑ Yes	**Rheumatism**	❑ No ❑ Yes
Haemophilia	❑ No ❑ Yes	**Asthma**	❑ No ❑ Yes	**Recent operations**	❑ No ❑ Yes
Cancer	❑ No ❑ Yes	**Slipped disc**	❑ No ❑ Yes	**Medical oedema**	❑ No ❑ Yes
Osteoporosis	❑ No ❑ Yes	**Trapped nerve**	❑ No ❑ Yes	**Heart condition**	❑ No ❑ Yes
Arthritis	❑ No ❑ Yes	**Postural deformity**	❑ No ❑ Yes	**Kidney infection**	❑ No ❑ Yes
Epilepsy	❑ No ❑ Yes	**Spastic condition**	❑ No ❑ Yes	**Nervous dysfunction**	❑ No ❑ Yes
Diabetes	❑ No ❑ Yes	**Undiagnosed pain**	❑ No ❑ Yes	**Bells Palsey**	❑ No ❑ Yes

Please check the boxes to accept the following statements:

❑ I have received GP consent for any condition, in bold above, that requires medical permission.

❑ I confirm that I have given this information to the best of my knowledge and I understand that it is my responsibility to give updates on any changes.

❑ I understand that there is a possibility of developing some minor reactions as my body adjusts to the treatment, particularly with deeper tissue work.

❑ I consent to having massage treatments based on the information I have provided and agree to my personal data being collected for this purpose.

Signature: _____ Date: _____