Naturally Chiropractic

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Massage consultation sheet

Name ..... Date of birth .....

Address .....

.....

Occupation ..... Is your job sedentary or active? .....

Telephone number ..... Mobile .....

Email ..... Preferred contact method? .....

Have you had a massage before? *yes* ☐ *no* ☐

Main areas of concern .....

What are your expectations from this treatment? .....

.....

How long have you had this problem? .....

Your health

Are you on blood pressure medication? *yes* ☐ *no* ☐ Is it? *high* ☐ *low* ☐

If so, for how long? .....

Do you suffer from regular headaches? *yes* ☐ *no* ☐

If yes, please describe what type of headache .....

Are you on any medication? *yes* ☐ *no* ☐

If yes, please give details .....

Are you currently being treated by your GP or another health professional for any condition? *yes* ☐ *no* ☐

If yes, please give details .....

Is there any chance you may be pregnant? *yes* ☐ *no* ☐

Our oil is nut based – do you have an allergy to nuts? *yes* ☐ *no* ☐ *If YES, don't worry, we have alternative oils.*

Have you had any surgery in the past 2 years? *yes* ☐ *no* ☐

If yes, please give details .....

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Do you suffer from any of the below conditions or another complaint or condition not yet mentioned?

osteoarthritis	☐	rheumatoid arthritis	☐	osteoporosis	☐	eczema	☐
dermatitis	☐	psoriasis	☐	melanomas	☐	diabetes	☐
asthma	☐	heart disease	☐	varicose veins	☐	phlebitis	☐
epilepsy	☐	cancer					

If yes, please give details .....

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Therapist's notes

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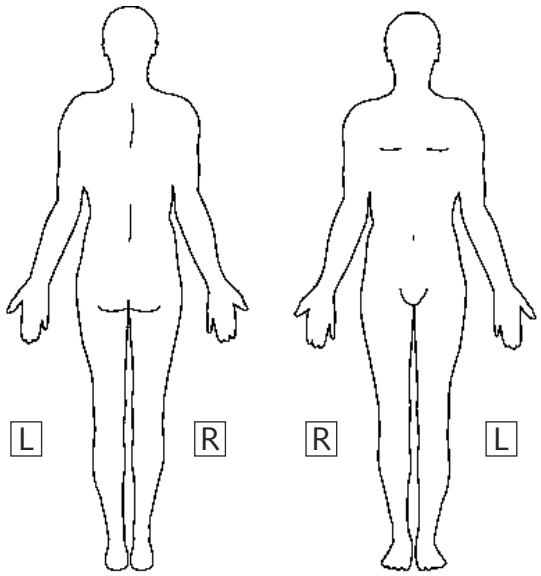

Thank you for taking the time to fill in this form.

Declarations: please acknowledge ALL following declarations. If you don't, we cannot accept you as a patient.

The above information is to the best of my knowledge true and correct ☐

I confirm I have read the following:
- Naturally Chiropractic Privacy Policies ☐
- Consent for Care and Data Collection ☐
- Expectations of Healing ☐

Having read these documents, I confirm that I wish to proceed with treatment at Naturally Chiropractic ☐

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

If under 18, I consent fo ..... to receive chiropractic care.

Signature of parent/guardian: ..... Date: .....