# CONSULTATION FORM

***Client note:***

The following information is required for your safety and to benefit your health. Whilst Indian Head Massage is a *very* safe treatment, there are certain contra-indications which may require special attention. The following information will be treated in the strictest of confidence and it may be necessary for you to consult your GP before treatment can be given.

Date of initial consultation: Ref:

**GENERAL**

Name: Tel. number:

Address:

D o B: Occupation:

**MEDICAL**

| Do you suffer with, or have you ever suffered from, any of the following: | **YES** | **NO** |
|---|---|---|
| Thrombosis or embolism | ☐ | ☐ |
| High or low blood pressure | ☐ | ☐ |
| Recent operation | ☐ | ☐ |
| Recent head or neck injury | ☐ | ☐ |
| Any dysfunction of the nervous system | ☐ | ☐ |
| Spastic condition | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Recent haemorrhage | ☐ | ☐ |
| Skin disorder or infection | ☐ | ☐ |
| Scalp infection | ☐ | ☐ |
| Are you currently under the influence of alcohol or drugs | ☐ | ☐ |
| **Is GP referral required** | ☐ | ☐ |

Name of Doctor: Surgery:

Address: Tel. number:

Current Medication:

Is your general health good / average / poor

**LIFESTYLE**

Stress levels: high /average / low
Energy levels: high /average / low
Emotional state: good / average / poor
Hobbies:

***Client declaration:***

I declare that the information I have given is correct, and as far as I am aware I can undertake treatments without any adverse effect. I have been fully informed about the contra-indications, and am willing to proceed with treatment.

**Client Signature:** **Date:**