<u>Thai Yoga Massage - Consultation form</u>

Date: DD / MM / YYYY
Client Id: _______________

Please fill up the form below. Your information are confidential.

Client Information

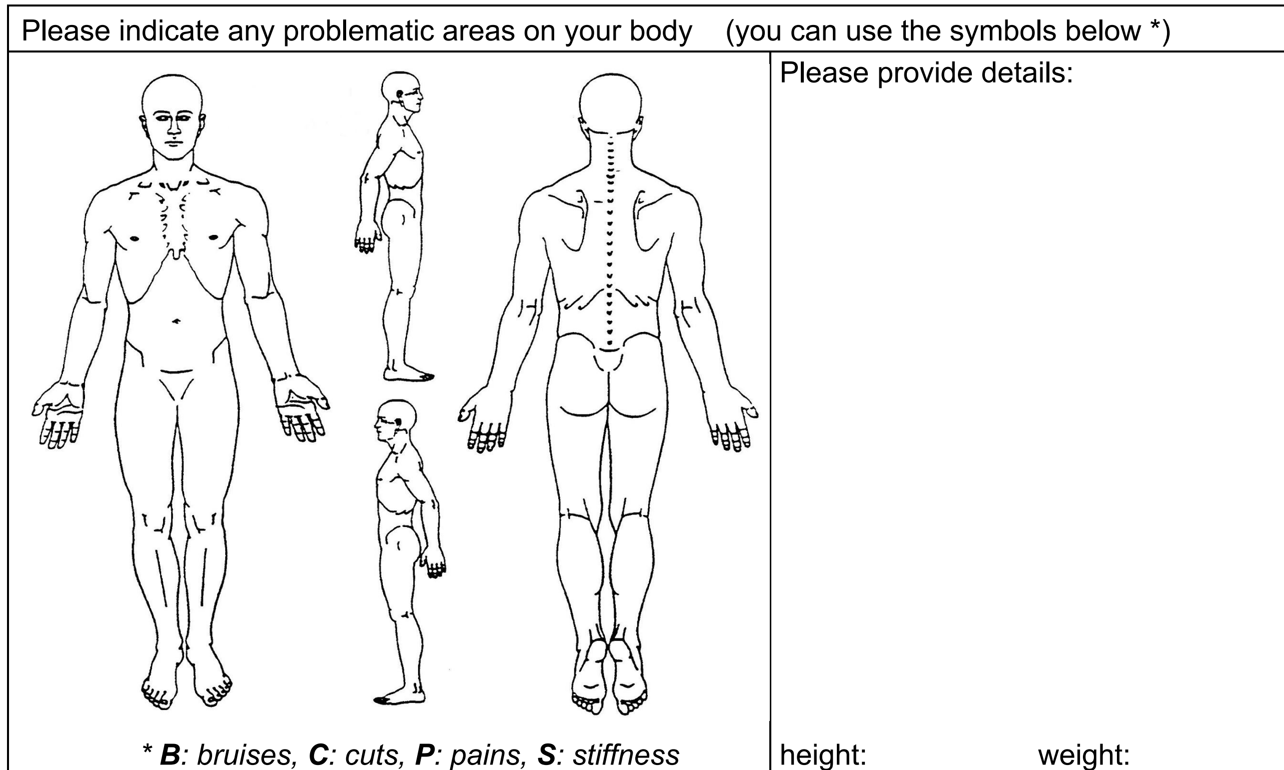
Name:	Gender: ***MALE / FEMALE***
Occupation:	(ladies only) Are you pregnant? ***YES / NO***
Phone number:	Marital status:
Email:	

Sleep patterns:	Stress level: *(low)* ***1 2 3 4 5*** *(high)*
Diet:	Energy level: *(low)* ***1 2 3 4 5*** *(high)*
How many cigarettes do you smoke per week?	
How much alcohol do you drink per week?	

Medical Information

Do you have any allergies? ***YES / NO***
If YES, please provide details:

Are you currently taking any medication? ***YES / NO***
If YES, please provide details:

Please indicate any problematic areas on your body (you can use the symbols below *)	
	Please provide details:
* ***B***: *bruises*, ***C***: *cuts*, ***P***: *pains*, ***S***: *stiffness*	height: weight:

please continue on next page...

Please indicate if you suffer from or have a history of any of the following:		
recent accident or injury ☐	headaches/migraines ☐	heart disorder ☐
recent operations ☐	dizziness ☐	fluctuating blood pressure ☐
back problems ☐	varicose veins ☐	thrombosis/embolism ☐
neck problems ☐	recent swelling/oedema ☐	asthma ☐
osteoporosis ☐	infectious diseases ☐	diabetes ☐
arthritis ☐	hernia ☐	epilepsy ☐
artificial joint ☐	current fever ☐	cancer ☐
broken/fractured bone ☐	current diarrhea ☐	nervous system dysfunction ☐
If you checked any of the above, please provide details:		

Do you have any other medical issues/conditions or surgical history? ***YES / NO***
If YES, please provide details:

Holistic Therapies

Have you had Traditional Thai massage before? ***YES / NO***
Please explain what your expectations are from this Thai massage:
Are you currently seeing a Chiropractor, Physical Therapist, Physician? ***YES / NO***
If YES, please give details. *How have these treatments helped you?*

Client Declaration

I declare that the information that I have given is true and correct and that, as far as I am aware, I can undertake treatment with this establishment without any adverse effects. I have been fully informed about contra-indications and I am willing, therefore, to proceed. I understand that massage therapy is not substitute for medical advice and/or treatment.

Client's signature	**Date:** DD / MM / YYYY
Therapist's signature	**Date:** DD / MM / YYYY

Please notify me should the information you have provided about your health change at any point.