

Massage Assessment Form

Please complete all details and questions as accurately as possible. All information provided will remain confidential.

Contact details

Name:

Address:

Contact numbers: Home:

Work/mobile:

Date of birth:

Contact details for next of kin:

Occupation:

Medical History

Please circle yes or no for the following questions:

a) Do you suffer from any medical conditions? Yes No

If yes, please circle those that apply and add any relevant details:

Asthma (or other respiratory conditions)

High blood pressure

Osteoporosis

Arthritis

Epilepsy

Cardiac/heart problems

Digestive complaints

Tumour

Diabetes

Cancer

Thrombosis

Haemophilia

Other (please state):

b) Are you currently on any medication? Yes No

If yes, please state which medications:

c) Have you noticed any recent unexplained weight loss? Yes No

d) Do you suffer from varicose veins? Yes No

e) Do you currently have any skin conditions or infections? Yes No

f) Have you previously had surgery? Yes No

If yes, please provide details: