# Masssage 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) | Epilepsy | Diabetes |
| High blood pressure | Cardiac/heart problems | Cancer |
| Osteoporosis | Digestive complaints | Thrombosis |
| Arthritis | Tumour | 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: