**LD Consultation Form**

Personal Information

Name:

Phone:

Address:

DOB :

Occupation:

Email:

GP:

Emergency Contact:

Medical Information Massage Information

Are you taking any medications? yes no Have you had a professional massage before? yes no

If yes, please list name and use:

Are you currently pregnant? yes no

If yes, how far along?

Any high risk factors?

Do you suffer from chronic pain? yes no

If yes, please explain

What makes it better?

What makes it worse?

Have you had any orthopaedic injuries? yes no

If yes, please list:

Please indicate any of the following that apply to you.

What type of massage are you seeking?

Relaxation YES/NO

Therapeutic/Deep Tissue YES/NO

What pressure do you prefer?

Light Medium Deep

Do you have any allergies or sensitivities? yes no

Please explain:

Are there any areas (feet, face, abdomen, etc.) you do not

want massaged? yes no

Please explain

What are your goals for this treatment session?

Please circle any areas of discomfort

Cancer Fibromyalgia

Headaches/Migraines Stroke

Arthritis Heart Attack

Diabetes Kidney Dysfunction

Joint Replacement(s) Blood Clots

High/Low Blood Pressure Numbness

Neuropathy Sprains or Strains

Explain any conditions you have marked above:

By signing below, you agree to the following.

I have completed this form to the best of my ability and knowledge

and agree to inform my therapist if any of the above information

changes at any time.

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_

Therapist Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_