

Good Vibe

Massage Therapy

**Consultation Form**

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Name: Address:

Phone:

Mobile: Email:

Occupation:

Age: Date of Birth:

(If under the age of 18, you need Parents Consent)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin Name and phone number:

GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you do any Physical Activities or have any Hobbies? If yes, please

list and including how often:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you eat a well balanced meals each day? Yes[] No[]

How many of the following drinks do you consume in a day?

Tea: Coffee: Fruit Juices: Water: Soft Drinks: Alcohol:

Do you smoke? Yes[] No[] How many per day? \_\_\_\_\_\_\_\_

Ability to relax: Good[] Moderate[] Poor[]

Sleep patterns Good[] Poor[] Average No. of hours \_\_\_\_\_\_\_

Stress Levels for home/work on a scale 1-10 (1 is low, 10 is high)

considering for eg: exercise, sleep, diet, physical/mental stress

Home:\_\_\_\_\_\_\_\_\_Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work:\_\_\_\_\_\_\_\_\_\_Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1.

Have you had a massage before? Yes[] No[]

Is there a specific area you would like to focus on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

or avoid\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently receiving treatment from a GP/Health Professional:

If yes, please give details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Current medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present or Past Operations, Injuries, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you recently consumed any alcohol or recreational drugs?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you Pregnant or trying to conceive?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Conditions**

Skin: Dermatitis[] Acne[] Eczema [] Psoriasis[]

Muscular: Sprains[] Stress[] Ruptures[] Muscular Distrophy[]

Skeletal : Break/Fractures[] Arthritis[] Osteoporosis[] Slipped disc[]

Circulation: Thrombosis[] Blood Pressure Low/High[] Varicose Veins[] Angina[]

Respiratory: Asthma[] Bronchitis[] Emphysema[] Fever/Cold/Flu[]

Lymphatic: Hodgkin’s Disease[] Lymphoma [] Oedema[]

Nervous: Epilepsy[] Multiple Sclerosis[] Migraine[] Stroke[]

Endocrine: Thyroid[] Hypoglycemia[] Diabetes[]

Reproductive: PMT[] Menopause[] Endometriosis[] Irregular periods[]

Urinary: Kidney stones[] Cystitis[] Diabetes[] Bladder/Bowel dysfunction[]

Digestive: Diarrhea[] Constipation[] IBS[] Nausea[]

Other: Cancer[] Contagious diseases[] Infections[]

If you have ticked any of the above , or if you would like to mention

anything not described, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Reason for Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Declaration: I have completed the form as fully and accurately as I can. I

believe the details to be correct and consent to having treatment.

I will advise in the future if any of my circumstances change.

Signature Date:

2.