SOOTHE & SCULPT

Full Body Massage, Lymphatic Drainage & Body Sculpting

Massage Consent Form

For best results it is recommended to use Adobe Acrobat to fill in this form.

Client's Information

Full Name:

Date of Birth: Age: ☐ Female ☐ Male ☐ NB

Address:

City: Post Code:

E-mail: Phone:

Doctors Name:

Address:

City: Post Code:

Treatment Information

What treatment are you having? ☐ Lymphatic Drainage / Wood Therapy ☐ Massage / Hot Stones

Why do you want the treatment?

Have you had this treatment before? ☐ YES ☐ NO

If yes, where and when?

Any concerns?

What do you do for work?

General Health

Is your general health	☐ Good	☐ Average	☐ Poor	
Are your energy levels	☐ High	☐ Average	☐ Low	
Is your stress level	☐ High	☐ Average	☐ Low	
Do you sleep	☐ Well	☐ Average	☐ Poorly	
Caffiene consumption	☐ None	☐ 1-2 Cups	☐ 3-4 Cups	☐ 5+ Cups
Water consumption	☐ <1L	☐ 1-2L	☐ 2-3L	☐ 3L+
Bowel movements	☐ Daily	☐ 2-3 Days	☐ Less Often	

Medical Information

Do you have, or have you ever had the following? :
(Please give details where applicable)

- [ ] Circulatory disorder
- [ ] Heart / liver / kidney conditions
- [ ] High or low blood pressure
- [ ] Thrombosis
- [ ] Varicose vein(s)
- [ ] Epilepsy
- [ ] Abdominal complaint
- [ ] Muscle conditions
- [ ] Diabetes
- [ ] Dysfunction of the nervous system
- [ ] Recent hemorrhage or swelling
- [ ] Recent operation / fracture / sprain
- [ ] Nut allergy
- [ ] Wheat allergy or intolerance
- [ ] A potentially fatal or terminal condition (e.g. cancer)

- [ ] Are you currently under GP or hospital care? Details:

- [ ] Are you taking any medication including herbal remedies? Please specify:

Female Clients

- [ ] Is it possible that you are pregnant?
- [ ] Do you suffer from PMS, pain, premenopausal / menopausal problems?
- [ ] Breastfeeding?

Health-Related Problems:

Do you have, or have you ever had the following? :

Skin complaints:

Other (please specify)

Circulation / Joints:

Other (please specify)

Stress / Anxiety:

Other (please specify)

Respiration:

Other (please specify)

Digestion:

Other (please specify)

Urinary problems:

Other (please specify)

Autoimmune conditions:

Other (please specify)

Immunosuppressive drugs:

Other (please specify)

Nervous system disorders:

Other (please specify)

Connective tissue disorders:

Other (please specify)

Any medications:

Other (please specify)

Inflammation disorders:

Other (please specify)

Emotional / cognitive issues

Other (please specify)

Respiratory problems:

Other (please specify)

Weight loss medication:

Other (please specify)

Recent illness:

Other (please specify)

Skeletal conditions:

Other (please specify)

Headaches or migraines:

Other (please specify)

Are there any other details not mentioned above which you would like help with as part of your treatment?

Are you currently undergoing any other complementary treatment? Please give details:

Summary of any problems you would like the treatment to address:

THERAPIST USE ONLY: Is GP referral required? ☐ **YES** ☐ **NO**

Please Note:

Our ethos is internal wellness and nervous system benefits. Visual result IF ANY are a bonus, not a gaurantee.

Consent and Agreement

I declare that the information I have given is correct and promise to notify the Therapist should there be any changes to my health. As far as I am aware, I can undertake treatment without any adverse effects. I have been fully informed about any contraindications and am willing to proceed with the treatment.

Client's Signature: _____ **Therapist's Signature:** _____

Date: _____ **Date:** _____

Soothe & Sculpt GDPR Notice:

Your personal and medical information is collected only to ensure safe, appropriate treatment. It is stored securely, never shared without your consent (unless legally required), and kept only for the period required by law and our insurer. You may request access, correction, or deletion of your data at any time by contacting us.