1. CLIENT INFORMATION

Field	Details
Date:	_____
Client Code:	
Full Name:	_____
Date of Birth:	_____
Address:	
Phone Number:	_____
Email:	_____
Emergency Contact (Name & Phone):	_____

2. GENERAL HEALTH

Question	Yes	No	Details (if yes)
Under GP or specialist care?	☐	☐	_____
Taking prescribed medication?	☐	☐	_____
Allergies (oils, nuts, fragrances, latex)?	☐	☐	_____

3. DETAILED MEDICAL CONDITIONS

Condition Category	Specific Conditions	Yes	No	Details (if yes)
Cardiovascular Health	High/low BP, heart disease, angina, pacemaker, stroke/TIA, clotting disorders, varicose veins, DVT	☐	☐	_____
Respiratory Health	Asthma, COPD, emphysema, chest infections, breathing issues	☐	☐	_____

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Condition Category	Specific Conditions	Yes	No	Details (if yes)
Neurological Conditions	Epilepsy, seizures, migraines, neuropathy, MS, Parkinson's	☐	☐	_____
Endocrine & Metabolic	Diabetes, thyroid disorders, adrenal disorders	☐	☐	_____
Musculoskeletal Issues	Arthritis, joint replacements, chronic pain, fibromyalgia, fractures, sprains	☐	☐	_____
Skin Conditions	Eczema, psoriasis, dermatitis, fungal infections, wounds, bruising	☐	☐	_____
Digestive & Abdominal Health	IBS, Crohn's, colitis, hernias, abdominal surgery	☐	☐	_____
Reproductive Health	Pregnancy, fertility treatment, menstrual pain, endometriosis	☐	☐	_____
Mental & Emotional Health	Anxiety, depression, PTSD, panic attacks	☐	☐	_____
Immune System	Autoimmune disorders, chronic fatigue, recent infections	☐	☐	_____
Cancer History	Current treatment, remission, lymph node removal, radiotherapy	☐	☐	_____
Medication Considerations	Blood thinners, steroids, pain medication, antidepressants	☐	☐	_____
Allergies & Sensitivities	Nuts, essential oils, fragrances, latex, adhesives	☐	☐	_____

4. CONTRAINDICATIONS

Absolute Contraindications

(Treatment should NOT proceed)

Condition	Yes	No	Notes
Fever or acute illness	☐	☐	_____
Contagious skin conditions	☐	☐	_____
Recent major surgery (<6 weeks)	☐	☐	_____
Deep Vein Thrombosis (current/suspected)	☐	☐	_____
Uncontrolled high blood pressure	☐	☐	_____

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Condition	Yes	No	Notes
Severe cardiovascular conditions	☐	☐	_____
Under influence of drugs/alcohol	☐	☐	_____

Local Contraindications

(Avoid or adapt specific areas)

Condition	Yes	No	Area to Avoid / Adaptations
Varicose veins	☐	☐	_____
Bruising, swelling, inflammation	☐	☐	_____
Cuts, wounds, recent scars	☐	☐	_____
Skin irritation or rashes	☐	☐	_____
Recent injections (vaccines, B12)	☐	☐	_____
Localised pain or injury	☐	☐	_____

Special Precautions

(Treatment can proceed with modifications)

Condition	Yes	No	Required Adaptation
Pregnancy (trimester?)	☐	☐	_____
Diabetes	☐	☐	_____
Osteoporosis	☐	☐	_____
High stress or anxiety	☐	☐	_____
Sensitivity to pressure	☐	☐	_____
Cancer history (lymphatic considerations)	☐	☐	_____

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5. TREATMENT SUITABILITY

Question	Yes	No	Details
Had massage/holistic treatments before?	☐	☐	_____
Areas you prefer not to be touched	—	—	_____
Comfortable with oils?	☐	☐	_____
Sensitive to strong scents (Aromatherapy)?	☐	☐	_____

Therapist Notes:

6. TREATMENT CONSENT

Consent Statement	Client Initials
I understand treatments are complementary and not a substitute for medical care.	_____
I will inform the therapist of any health changes.	_____
I consent to the selected treatment(s).	_____
I understand I may stop the treatment at any time.	_____
I confirm all information provided is accurate.	_____

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

7. GDPR & DATA PROTECTION CONSENT

Statement	Tick
I consent to my personal data being stored securely for treatment and insurance purposes.	☐
I understand my rights under GDPR.	☐
I consent to being contacted regarding appointments or treatment updates (optional).	☐

Client Signature: _____ **Date:** _____

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