Revival Massage Therapy

Confidential Client Information

Thanks for taking the time to complete this form; it will assist with your massage session.

Name: _____
Address: _____
_____
Phone Number: _____ email: _____
DO.B____/_____/____Occupation: _____
Where did you hear about revival massage _____

Current Conditions (tick if any)

Headaches		High/Low Blood pressure		Diabetes	
Numbness/Tingling		Varicose Veins		Asthma	
Dizziness		Blood Clots		Allergies	
Fluid Retention		Skin Problems		Hernia/Ulcer	
Chest Pains		Vision Problems		Arthritis/Gout	
Easy Bruising		Sleep Disturbance		Epilepsy	
Breathing Problems		Menstrual Problems		RSI/OOS	
Digestive Problems		Menopausal Symptoms		Viral Condition	
Heart Problems		Pregnancy		Infection	
Stress					

Current Medical Treatment/Medication (include Homeopathic)
_____
_____

Past Injuries/operations/Conditions _____
_____

Sports/Exercise/Recreational activities: _____

Previous Massage Experience: Often ☐ At times ☐ Never ☐
Do you have difficultly lying on your back/front _____

Current Complaint (please describe the location and the sensations where possible - Sore, tight, achy, numbness, tearing, sharp, generalised, specific???)
_____
_____
_____

What are your goals for todays massage session??
(What are you hoping for massage to assist with?? Areas to massage?)

Please contact me if you have any severe or ongoing effects after the massage.
Please address any concerns or complaints firstly to this practitioner or if not resolved to The Health and Disabilities Commission, PO Box 1791, Auckland. I certify that I have completed this form to the best of my knowledge and consent to treatment based on the information provided.

Client signature: _____ Date: _____