**Date:** Click here to enter a date.

|  |  |
| --- | --- |
| **Name:** |  |
| **Address:****Post Code** |  |
| **Profession:**  |  |
| **Telephone No/s** |  |
| **Email** |  |

 **PERSONAL DETAILS**

**Age group:** Under 20 [x]  20-30 [x]  30-40 [x]  40-50 [x]  50-60 [x]  60+ [x]

**Lifestyle:** Active [x]  Sedentary [x]  **Last visit to the doctor:**

**GP address:**

**Number of children (if applicable):**  **Date of last period (if applicable):**

**CONTRAINDICATIONS REQUIRING MEDICAL PERMISSION – in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment.** (Select if/where appropriate):

Pregnancy [x]

Cardio vascular conditions (thrombosis, phlebitis,

Hypertension, hypotension, heart conditions [x]

Haemophilia [x]

Any condition already being treated by a GP or

Another complimentary therapist [x]

Medical oedema [x]

Osteoporosis [x]

Arthritis [x]

Nervous/Psychotic conditions [x]

Epilepsy [x]

Recent operations [x]

Diabetes [x]

Asthma [x]

Any dysfunction of the nervous system (e.g.

Multiple sclerosis, Parkinson’s disease,

Motor neurone disease) [x]

Bell’s palsy [x]

Trapped/Pinched nerve (sciatica) [x]

Inflamed nerve[x]

Cancer[x]

Postural deformities[x]

Cervical spondylitis[x]

Spastic conditions[x]

Kidney infections[x]

Whiplash[x]

Slipped disc[x]

Undiagnosed pain[x]

When taking prescribed medication[x]

Acute rheumatism[x]

**CONTRAINDICATIONS THAT RESTRICT TREATMENT** (Select if/where appropriate)

Fever[x]

Contagious or infection diseases[x]

Under the influence of recreational drugs or alcohol[x]

DIarrhoeea and vomiting [x]

Skin diseases

Undiagnosed lumps and bumps [x]

Localised swelling [x]

Inflammation [x]

Varicose veins [x]

Pregnancy (abdomen) [x]

Cuts [x]

Bruises [x]

Abrasions[x]

Scar tissue (2 yrs for major operation, 6 months small scar) [x]

Sunburn [x]

Hormonal implants [x]

Menstruation (abdomen -first few days) [x]

Haemotoma [x]

Hernia [x]

Recent fractures [x]

Gastric ulcer [x]

After a heavy meal [x]

Conditions affecting the neck [x]

**WRITTEN PERMISSION REQUIRED BY** (Select if/where appropriate):

GP/Specialist[x]  Informed consent[x]

Either of which should be attached to the treatment form.

**PERSONAL INFORMATION** (Select if/where appropriate):

**Muscular/Skeletal problems:** Back [x]  Aches/Pains [x]  Stiff joints [x]  Headaches [x]

**Digestive Problems:** Constipation [x]  Bloating Liver/Gall bladder [x]  Stomach [x]

**Circulation:** Heart [x]  Blood pressure [x]  Fluid retention [x]  Tired legs [x]  Varicose veins [x]

Cellulite [x]  Kidney problems [x]  Cold hands and feet [x]

**Gynaecological:** Irregular periods [x]  P.M.T [x]  Menopause [x]  H.R.T [x]  Pill [x]  Coil [x]  Other [x]

**Nervous system:** Migraine [x]  Tension [x]  Stress [x]  Depression [x]

**Immune system:** Prone to infections [x]  Sore throats [x]  Colds [x]  Chest [x]  Sinuses [x]

**Regular antibiotic/medication taken?** Yes [x]  No [x]  If yes, which ones

**Herbal remedies taken?** Yes [x]  No [x]  If yes, which ones

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

**Sleep patterns:** Good [x]  Moderate [x]  Poor [x]

**Do you see natural daylight in your workplace?** Yes [x]  No [x]

**Do you work at a computer?** Yes [x]  No [x]  If yes, how many hours per day

**Do you eat regular meals?** Yes [x]  No [x]

**Do you eat in a hurry?** Yes [x]  No [x]

**Do you exercise?** Yes [x]  No [x]  If yes, which ones

**Do you take any food/vitamin supplements?** Yes [x]  No [x]  If yes, which ones

**How many units of these drinks do you consume per day?**

Tea: Coffee: Fruit juice: Water: Soft drinks: Others:

**Do you suffer from allergies?** Yes [x]  No [x]

**Do you suffer from eating disorders?** Bingeing? Yes [x]  No [x]  Overeating? Yes [x]  No [x]  Undereating? Yes [x]  No [x]

**Do you smoke?** Yes [x]  No [x]  If yes, how many per day?

**Do you drink alcohol?** Yes [x]  No [x]  If yes, how many units per day?

**Do you exercise?** None[x]  Occasional Irregular[x]  Regular[x]  Types

**What is your skin type?** Dry[x]  Oily[x]  Combination[x]  Mature[x]  Young[x]  Normal[x]

**Do you suffer/have you suffered from:** Dermatitis[x]  Acne[x]  Eczema[x]  Psoriasis[x] Allergies[x]  Hayfever[x]  Asthma[x]  Skin Cancer[x]

**Stress level: 1-10** (10 being the highest)

At work: At home:

**Sign Form Here:**

**Email** your finished form to pauline@paulineblackwood.co.uk

Your appointment is one step closer

**Thank you for choosing Pendulum Massage**