

Health Questionnaire

Surname:		Please tick one of the following; Have you been:	
Forename:			
Address:		Referred by a Professional	
		Self-referred	
Telephone No:		If a Professional has referred you, please provide details below:	
Date of Birth:			

Doctors Name:		Telephone No:
Surgery Address:		

Occupation:		Do you work at a desk?:
-------------	--	-------------------------

Give a rough guide to your lifestyle and sporting interests				
	Not At All	Occasional	Regular	Daily
Water consumption				
Coffee/Tea consumption				
Alcohol consumption				
Cigarette consumption				
Gentle exercise				
Moderate exercise				
Rigorous exercise				

Type of exercise you partake in and any special interest sports:

Give a brief description of your diet: (e.g., vegetarian, healthy, moderately healthy, etc)

Please take a moment to fill in the following questionnaire about any health issues you are suffering from:

	Yes	No	(Notes)		Yes	No	(Notes)
Hypertension/Hypotension				Flu/Viral Infection			
Recent Fractures				Thrombosis			
Unstable Pregnancy				Recent Operation			
Stable Pregnancy				Inflammation			
Menstruation				2-3 Hrs Post Full Meal			
Epilepsy				Cuts			
Cardiovascular Disease				Bruising			
Skin Disorder				Haemophilia			
Nervous System Disorder				Allergies			
Auto Immune Disorder				Metal Plates/Pins			
Cancer				Pacemaker			
Diabetes				Current Ingestion of			
Phlebitis				Antibiotics			
Varicose Veins				Recent Sprain/Strain			

Any other relevant information:

Clients disclaimer

I agree that I have given all relevant information, and completed the enclosed health questionnaire to the best of my knowledge. Should any changes occur to my state of health, I agree to disclose this information prior to any massage treatment occurring.

Clients Signature: _____

Clients Printed Name: _____ Date _____

Office Use Only:

Is there GP/Physiotherapist/Chiropractor approval required: **Yes/No**

The client has been advised on _____ to consult with a relevant professional, regarding the contra-indications listed overleaf.

Therapists Signature: _____

Client Account of Professional Opinion:

Medical Advice:

Clients Signature: _____

Clients Printed Name: _____ Date _____