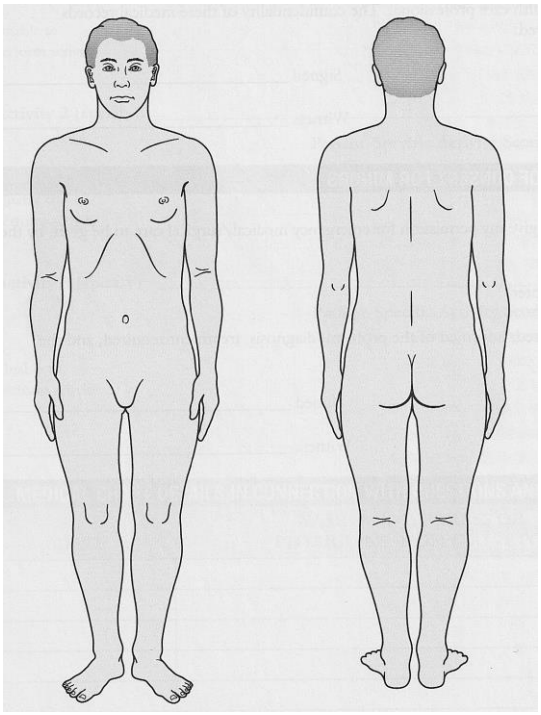
Name:	Date of Birth
Address:	Post Code
Phone:	E-mail:
Doctors Details & Phone: (if known)	

Massage by Chris Client Information and Consent Form

An accurate health history ensures it is safe for you to receive a massage treatment and allows me to determine a proper treatment plan. If your health status changes between treatments, please let me know before your next treatment.

All information gathered on this form is confidential. Your written authorization is legally required before any of this information can be released.

Please identify area(s) of concern/that you would like treated/not treated below & circle the areas.



Please identify if you suffer from any of the following:

- Allergies
- Cancer
- Breathing Problems / Asthma / COPD
- Heart Conditions / High / low blood pressure
- Diabetes / Epilepsy
- Thrombosis / varicose veins
- Joint / muscular problems
- Fainting / Bruise easily
- Skin conditions / Fungal conditions
- Other

Any previous surgery/fractures/sprains/serious illnesses?

Please list any medication taken

Do you take any regular exercise?

Are you currently under the care of any of the following? (Please state who and reason)
Doctor, Physiotherapist, Chiropractor, Osteopath, Massage Therapist, Naturopath, other:

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Federation of Holistic Therapists.

I give my consent for my therapist to treat me with massage therapy and that massage therapy is not a substitute for a medical examination and that it is recommended that I attend my GP for any ailments that I may be experiencing.

PRINT NAME: _____
SIGNATURE : _____
DATE : _____

FHT MEMBER