

CORNISH MASSAGE AND WELLBEING CONSULTATION FORM

DATE:

CM REF:

In line with data protection, all information you provide here will be treated as confidential and your data will not be shared with anyone outside of Cornish Massage and Wellbeing.

ABOUT YOU

NAME

DATE of BIRTH

PHONE NUMBER

In case we need to contact you about your treatment or appointment.

AGE TODAY

EMAIL

In case we need to contact you about your treatment or appointment.

GENDER

Relevant in certain treatments, product use & conditions.

ADDRESS

GP/SURGERY NAME

Required in the event of a contra-action

SURGERY PHONE

PROFESSION/LIFESTYLE

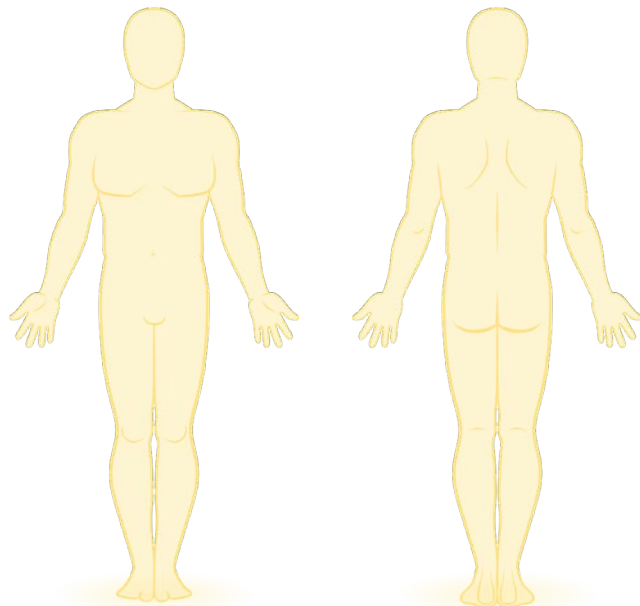
To determine daily mobility or stress levels.

SURGERY ADDRESS

We will not contact your GP without your consent.

YOUR GOALS

Briefly explain the issues that have brought you here today and, what you would like to achieve from your treatment



CIRCLE ANY AREAS ON THE BODY
REQUIRING SPECIAL ATTENTION

Select a box or more

Aid Recovery

Relieve Muscle Tension

Ease Pregnancy Strain

Skin Care

Relaxation

Uplifting Detox

CM - RECOMMENDED COURSE OF ACTION

CM Signature

Client Signature

Name

Date

Name

Date

Our website and social media are kept up to date with all our news and offers. We don't send newsletters or bombard your inbox with spam or store your details in an online database. But if you do like pleasant surprises via email rather than scrolling through feeds - put a tick in the box and we'll keep you in the loop!

Yes! I would like Cornish Massage special offers, rewards, news and birthday treats via email

CORNISH MASSAGE AND WELLBEING

WELLBEING FORM

DATE:

CM REF:

The answers you can provide here are aimed at your safety. This medical section highlights any issues which may require special attention or if you should consult your GP before starting any course of treatments. In line with data protection, all information you provide here will be treated as confidential and your data will not be shared with anyone outside of Cornish Massage and Wellbeing.

MEDICAL NOTES

Do you have any of the following conditions or symptoms which may prevent or restrict treatment?

Allergies *[please state]*

Asthma

Back injury - recent

Blood pressure - high/low

Bruising

Cancer

Cardiovascular condition *[please state]*

Chemotherapy treatment - recent

Cuts or abrasions

Deep vein thrombosis

Diabetes

Diarrhoea

Eczema

Epilepsy

Fever

Haemophilia

Haemorrhage - recent

Head injury -recent

Hernia

Lumps - undiagnosed

Medical oedema - recent

Meningitis

Migraines

Neck injury - recent

Nervous system disorder *[please state]*

Operations - recent

Osteoporosis

Pain – undiagnosed

Pregnant

Psoriasis

Radiotherapy - recent

Scar tissue - recent

Skin disorder – *contagious bacterial, viral or fungal*

Sunburn

Swelling

Varicose veins

Vomiting

Alcohol *[in last 24hrs]*

Drugs *[recreational in last 24hrs]*

Other medical history to be aware of

Other treatments, medicines or therapies to be aware of

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