Massage Solutions
MASSAGE THERAPY IN PLYMOUTH

Please complete the details below and return to Massage Solutions prior to treatment. By signing this form you are giving permission for it to be stored in accordance with GDPR Regulations.

Name *

First Name Last Name

Address

Street Address

Street Address Line 2

City County

Postcode

Phone Number *

Area Code Phone Number

Email *

example@example.com

How did you hear about Massage Soutions? *

List any medications, supplements, or herbal remedies you currently take: *

Please list allergies or sensitivities: *

Please list Injuries or surgeries: *

Have you ever been advised to avoid massage therapy due to any condition? *

Yes Facial

Preferred massage pressure?

What are your specific muscular and/or relaxation concerns currently? *

What is your stress level right now? *

- ☐ Low
- ☐ Average
- ☐ Somewhat Stressed
- ☐ Very Stressed

Describe your daily activity? *

Contraindications. Please tick all that apply, if any box is ticked I will be calling to discuss in more

detail. If no box is ticked and you still have questions that you would like to dicuss, please indicate in the notes below. Some contraindications may require GP consent prior to massage or an alternative appointment date. *

- ☐ Pregnant
- ☐ Postpartum
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Headaches
- ☐ High or low blood pressure
- ☐ Diabetes
- ☐ Knee/Leg Pain
- ☐ Jaw Pain / Clenching/ Grinding
- ☐ Fibromyalgia
- ☐ Autoimmune Condition (Celiac, Hashimotos, Lupus, Graves, etc)
- ☐ Endocrine / Thyroid Condition
- ☐ Multiple Sclerosis
- ☐ Fibromyalgia
- ☐ Neurological Condition (ALS, MND, Parkinsons, etc)
- ☐ Chronic Numbness / tingling
- ☐ Blood clots
- ☐ Pacemaker
- ☐ Congestive Heart Failure
- ☐ Varicose veins
- ☐ Stroke/Heart attack
- ☐ Asthma or shortness of breath
- ☐ Epilepsy or seizures
- ☐ Digestive disorder (IBS, Chrohns, Colitis ets
- ☐ Kidney Disease / Chronic UTI's
- ☐ Arthritis or arthritic condition
- ☐ Scoliosis/kyphosis/lordosis
- ☐ Osteoporosis
- ☐ Degenerative spine or discs
- ☐ Fever
- ☐ Under the influence of alcohol or drugs
- ☐ Diarrhoea or vomiting
- ☐ Skin disorders (eczema, psoriasis,acne, rosacae, vitiligo etc)
- ☐ Bruising, cuts or abrasions
- ☐ Allergies
- ☐ Phlebitis
- ☐ Anaphylaxis

- [ ] Any infectious disease
- [ ] HIV
- [ ] Broken bones
- [ ] Other -please detail below
- [ ] I have no contraindications to massage

Please add any details of contraindications here. If you would like to receive a call to discuss anything, please note this here.

Date of birth *

Month Day Year

What is your goal for this session. *

Date *

Month Day Year