**Sports and Remedial Massage**

Client History form

Client Details:

Identify as M F O

Full name: Phone No: D.O.B.: / /

Address: Email:

Emergency contact Name: Phone No:

Relationship:

Contraindications and medical History: (Tick Yes or No)

1. Are you pregnant? Yes / No

   If yes, how many weeks

2. Do you have any difficulty lying on your front, back, or side? Yes / No

If yes Please explain:

3. Varicose veins Yes / No
4. Recent surgery/ scar tissue Yes / No
5. Major operations/ accident Yes / No
6. Inflamed/ painful areas Yes / No
7. Circulatory disorders Yes / No
8. High/low blood pressure Yes / No
9. Pacemaker Yes / No
10. Supplements Yes / No
11. Diabetes Yes / No
12. Skin disease Yes / No
13. Allergy Yes / No
14. DVT/ blood clots Yes / No
15. Fractures/ sprain Yes / No
16. Raised temperature Yes / No
17. Headaches/ migraines Yes / No
18. Medications Yes / No If yes, please list:

I (client full name) understand and agree to the following:

- Understand that if I am late for a session, the session time may be cut short and the full fee will still apply.
- Ensure therapist is informed of any cancellation of a session at least 24 hours prior to the scheduled time and understand that if they haven't informed then the fee for the session will still stand.
- Has the right to refuse or stop session for any reason.
- Responsibility to notify the therapist of any discomfort or pain arising due to the session performed

I Argee: To the following terms and conditions of this service

send your completed form to fittoxhelp@gmail.com 0r Print this form and bring it to your next appointment