Seated Acupressure Massage - Health Questionnaire

Name: **DOB:**

Mobile no: **Email address:**

I will tailor the massage specifically for you. In order that you get the maximum benefit from your massage please answer the following questions and bring the form along with you at your 1st session:

If the answer to any question is 'Yes', please include more details overleaf

Are you presently undergoing any other treatment eg physiotherapy	Y/N
Ladies are you pregnant or trying to conceive?	Y/N
Are you taking any medication?	Y/N
Do you have high or low blood pressure?	Y/N
Do you ever feel faint /susceptible to low blood sugar or have a history of diabetes?	Y/N
Have you eaten recently if so what?	Y/N
Do you have any aches, pains areas of tension, arthritis or joint problems?	Y/N
Do you have any skin conditions, allergies, sensitive skin, cuts, bruises, burns?	Y/N
Have you had recent surgery?	Y/N
Do you have a heart problem?	Y/N
Have you had epilepsy?	Y/N
Any TB/osteoporosis?	Y/N
Any recent or past injuries?	Y/N
Any other health condition?	Y/N

Are there any area of the body that you wish me to avoid today – BACK SHOULDERS ARMS HANDS HEAD?

I understand that all the seated acupressure treatment given today is primarily for the reduction of stress and muscular tension. Because the therapist must be aware of any existing conditions, I have stated all known medical conditions and verify that the information on this form is true and correct. All the information above will be treated with the strictest of confidence.

Signed **Date:**

IMPORTANT NOTES

LADIES PLEASE WEAR TROUSERS OR A LOOSE SKIRT

DO NOT HAVE A BIG MEAL BEFORE YOUR TREATMENT BUT PLEASE ENSURE YOU HAVE HAD A LIGHT SNACK IN THE LAST COUPLE OF HOURS