***Massage Services – Susanna Romoli: Client Consultation Form***

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| --- | --- |
| **First name:** |  |
| **Surname:** |  |
| **Address:** |  |
| **Postcode:** |  |
| **Email:** |  |
| **Phone No:** |  |
| **Date of Birth:** |  |

**Health Record**

Do you suffer from any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| **Category** | **Y** | **N** | **Details (if applicable)** |
| Back problems  |  |  |  |
| Circulatory disorders  |  |  |
| Diabetes  |  |  |
| Asthma  |  |  |
| Epilepsy  |  |  |
| Allergies |  |  |
| Heart Conditions |  |  |
| High/Low blood pressure |  |  |
| Skin conditions |  |  |
| Thyroid conditions |  |  |
| Serious illness |  |  |

Are you taking any medication?

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| --- |
| Details: |

Have you had any recent operations, serious illnesses within the last 12 months?

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| --- |
| Details: |

**Travel and COVID-19**

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| --- | --- |
| Have you travelled outside of the UK or been in contact with someone that has in the last 14 days? |  |
| Can you confirm to the best of your knowledge that you haven’t been in contact with someone that has any of the COVID-19 symptoms? |  |
| Are you fit and well and don’t have any of the COVID-19 symptoms? |  |
| Have you had a COVID-19 vaccine in the last two weeks? |  |
| Have you had a positive COVID-19 test? |  |

Are you pregnant or trying to become pregnant?

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How did you hear about me?

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|  |

I can confirm that the information provided is a full and accurate statement of my current medical status. If this changes I will inform you.

Print name:

Signed:

Date: