Complete Health
CHIROPRACTIC - PHYSIOTHERAPY - MASSAGE

Patient Contract for Massage Clients

Name _____ Date of Birth _____

Address _____ Post Code_____

Home Phone _____ Mobile _____

Occupation _____ Email _____

Emergency contact name and number_____

Reason for consultation _____

Whom may we thank for referring you to us? _____

Have you ever had Deep Tissue / Sports massage before? Yes / No

Have you had any injuries or traumas? Yes / No _____

Have you had any surgeries? Yes / No _____

Are you taking any medication? Yes / No _____

Any known allergies? _____

Do you suffer with or have you suffered with any of the following (Please circle)

Neck / Chest / Shoulder pain	Dizziness / Fainting / Ringing in the ears
Upper / Mid / Low back pain	Heart problems
Arm / Wrist / Hand pain	High / Low blood pressure / Poor circulation
Hip / Knee / Ankle / Leg pain	Palpitations
Headaches / Migraines	Blood clots / Phlebitis
Trapped nerves	Varicose veins
Pins & Needles / Numbness	Breathing problems / Asthma
Arthritis	Indigestion / Constipation
Osteoporosis	Liver / Kidney / Bladder
Morning stiffness	Skin rash / Eczema / Psoriasis
Fibromyalgia / Chronic Fatigue	Inflammation / Swelling
Stress / Depression / Post-natal depression	Diabetes
Panic attacks	Hot sweats
Sleep problems	Cancer
Other (please specify)	

Women Only

Hot flushes / Night sweats	Painful menstruation / Irregular cycle
Heavy menstruation	PMS

PLEASE READ THE FOLLOWING AND SIGN

I have stated all my known physical conditions, medical conditions and medications and I will keep the massage therapist updated on any changes.

I understand that massage therapy is not a substitute for a medical examination or medical care and that it is recommended that I am also working with my primary care giver for any condition I may have.

Following massage therapy, you may experience short term sensations such as fatigue, headache, muscle soreness and achiness, feeling hot / cold, dehydration, heightened emotional symptoms.

Please rest and drink plenty of water after a treatment. In addition, it is best to avoid caffeine, alcohol and spicy food following your treatment.

- The information provided in this form is accurate to the best of my knowledge and recollection. No information that can contraindicate my treatment has been omitted.
- I consent to having an examination with the therapist. I understand that the results will be provided verbally, and I consent to treatment following this information.
- I agree to settle the cost of such treatment on the same day.
- I understand the risks and benefits of treatment and have been given the opportunity to ask questions to my satisfaction.

GDPR

- We reserve the right to contact you via post, email, text message or phone in relation to appointment reminders, requests and other aspects of your care.
- **Please tick the box to give consent for Complete Health to contact you as per the methods stated above** ☐
- I hereby consent to this information and any subsequent information pertaining to my examination and treatment to be retained and stored by this clinic (Complete Health Eastbourne). In accordance with the clinic privacy policy and the General Data Protection Regulation (GDPR)(EU) 2016/679.
- PLEASE NOTE THAT 24 HOURS NOTICE MUST BE GIVEN TO CANCEL OR ALTER A SESSION, FAILING WHICH A CHARGE OF £15.00 WILL BE PAYABLE.

- Client signature…… Date……
- Parent or guardian (if client is under 18 years old) ……
- OFFICE USE CLIENT REF NO ☐