BEE - CHI MASSAGE

CONSULTATION FORM

Treatment date:	Time:

PATIENT INFORMATION

Name:	❑ Male ❑ Female	Date of birth: ___/___/___ Or age:
Address:		
Tel:		
Occupation:		L or R handed:
Sports/Hobbies:		❑ L ❑ R
Pregnant or trying to become pregnant:		

LIFESTYLE

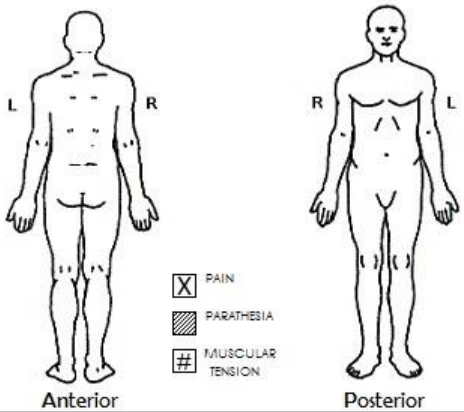
Energy Levels 1 – 10:		Stress Levels 1 – 10:	
Sleep (no of hours):		Daily water intake:	
Weight:		Height:	
Cigarettes per day:		Units of alcohol/week:	

MEDICAL HISTORY

Medication:
X-Rays/Scans:
Allergies:
Children/births:
Fractures:
Accidents:
Operations:
Hospitalisations:
Past illnesses:
Family history of illness:
Previous treatment:
Other issues:

ASSESSMENT

Primary problem:		
Pain (0 – 10):	**OR**	Musc. Tension (0 – 10):
Any other problems:		
I have stated all my known medical conditions, in confidence, and take it upon myself to keep the therapist updated on my physical health. I consent to this consultation, assessment and treatment which will involve soft tissue techniques.		



Patient/Guardian signature:	*Date:*

IN CASE OF EMERGENCY			
Name of local friend or relative	Relationship to patient:	Home phone no.:	Work phone no.:

Please do not post or e-mail any sensitive documents such as completed consultation forms. Completed consultation forms can be bought along to your appointment or feel free to contact us should you wish to discuss any queries you may have.