PAMPERMASSAGE

Professional relaxation ...

Consultation Form

Name: Date of 1st Treatment:

Email: Phone No:

DOB: Emergency Contact:

- Are you/could you be pregnant?
- Allergies
- DVT/blood clot risk
- Infections/colds/fever in the last week?
- Skin conditions
- Had any vaccines recently? If so what were they for ?

- Any current medical diagnosis?

- Are you currently under the care of any medical professionals/complementary health practitioners?

- Reason for seeking treatment?

- Desired Outcome

- Any additional information