TINA NORTH – QUALIFIED RAYNOR MASSAGE THERAPIST

MEDICAL QUESTIONAIRE AND CONSENT FORM

Please fill in the form below

FULL NAME

D.O.B. / /

FULL ADDRESS (Including Postcode)

HOME PHONE

MOBILE PHONE

OCCUPATION

DO YOU HAVE ANY INJURIES AT PRESENT (If yes please give details) YES/NO

HAVE YOU HAD ANY OPERATIONS IN THE LAST FIVE YEARS (If yes please give details) YES/NO

DO YOU OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS?

ASTHMA ☐ EPILEPSY ☐ STROKE ☐ HEART ATTACK ☐ OSTEOPOROSIS ☐

MIGRAINE ☐ CANCER ☐ VARICOSE VEINS ☐ HIGH/LOW BLOOD PRESSURE ☐

ARE YOU TAKING ANY RECREATIONAL DRUGS, NATURAL OR PHARMACEUTICAL MEDICATION. YES/NO
(If yes please give details)

DO YOU DO REGULAR EXERCISE. (If yes please give details with hours per week) YES/NO

DO YOU HAVE ANY ALLERGIES OR ARE YOU ALLERGIC TO ANY ESSENTIAL OILS. (If yes please list) YES/NO

DO YOU OR HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING? (F = FEMALES ONLY)

ANXIETY ☐ PHOBIAS ☐ DEPRESSION ☐ NERVOUSNESS ☐ ANGER ☐ ANOREXIA ☐ PMT (F) ☐

POSTNATAL DEPRESSION (F) ☐ MENOPAUSE (F) ☐ ADDICTION ☐ MOOD SWINGS ☐ INSOMNIA ☐

ARE YOU PREGNANT AND/OR LACTATING (Females YES/NO

HAVE YOU OR ARE YOU SUFFERING FROM ANY FURTHER CONDITIONS OR AILMENTS THAT ARE NOT LISTED THAT YOU WOULD LIKE YOUR THERAPIST TO BE AWARE OF (If yes please give details)

I, THE UNDERSIGNED, HEREBY STATE THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

FULL NAME (PLEASE PRINT)	SIGNATURE	/ / DATE