The Jing Method: Deep Tissue & Holistic Massage
Confidential Consultation Form

Personal Details

Full Name:		Date of 1st Treatment	
Tel. No.		D.O.B.	
Email:		Referral:	
Emergency Contact:		Tel. No.	

GP Information

GP Name/ Surgery		GP. Tel No.	
GP Address:		Initial here if you give your consent for your therapist to contact your doctor's surgery if they deem it necessary	

Health History

Question:	Notes:
☐ Are/could you be pregnant? Number of wks?	
☐ Allergies	
☐ DVT/blood clot risk	
☐ Infection/colds/fever in the last week?	
☐ Skin conditions	

Any current medical conditions diagnosis'?

Are you currently taking any medication or supplements? If yes, how do they make you feel? Any noticeable side effects?

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

Reason for seeking treatment

The Jing Method: Deep Tissue & Holistic Massage
Confidential Consultation Form

Desired Outcome

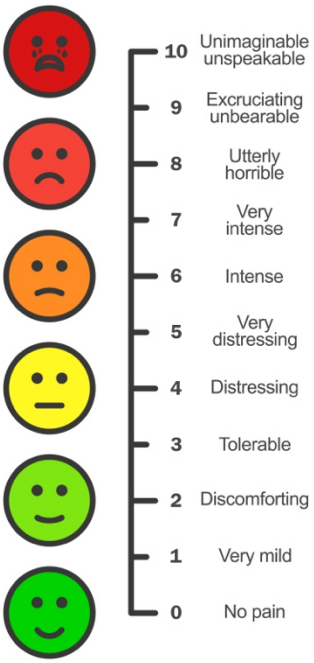
Massage Information

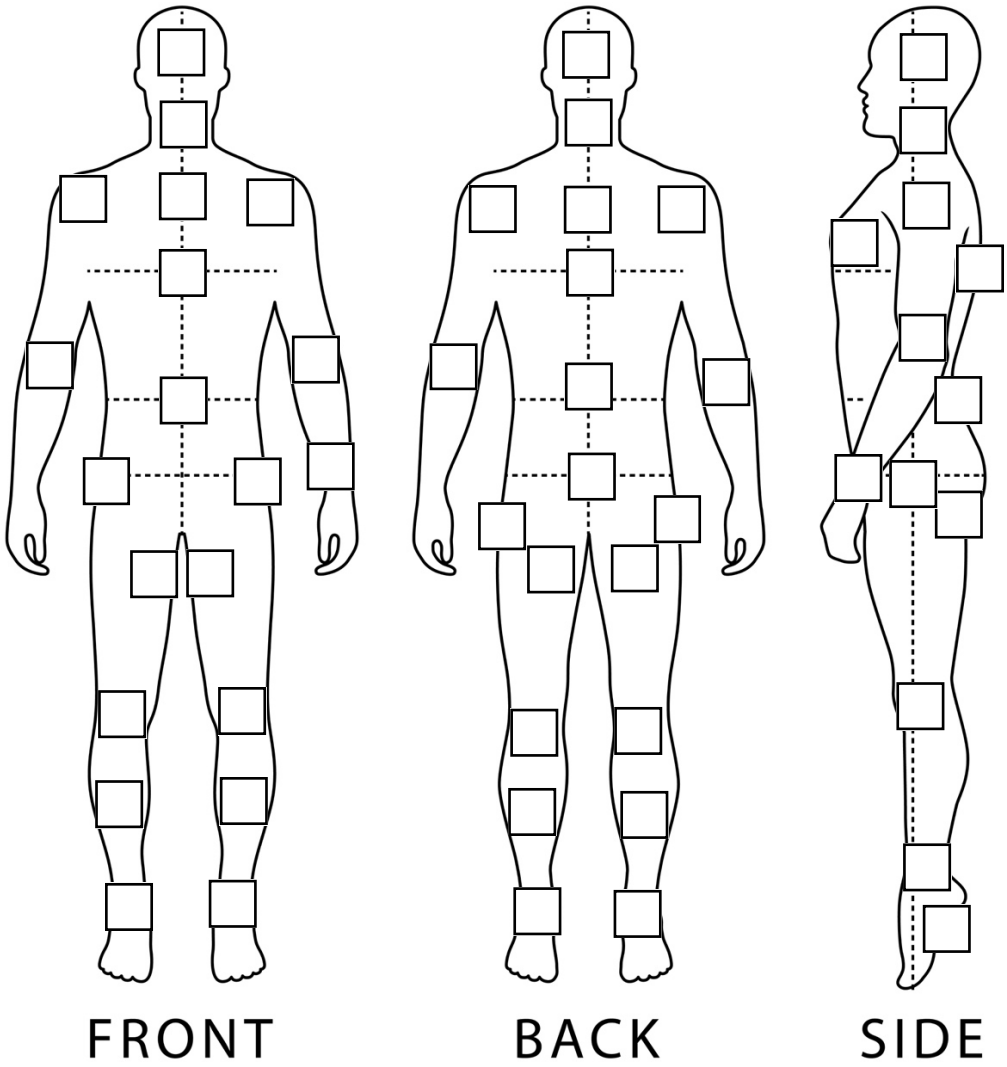
Have you ever had a professional massage before? Have you experienced The Jing Method before?

If yes, what did you like/dislike? (Pressure? Favourite areas to be massage? Any areas you dislike

Any Additional Information

Observation





Observation Notes

Informed Consent and GDPR

Informed Consent:

- I have had a thorough consultation with my chosen practitioner
- I have been informed of the proposed treatment plan and agree to proceed with my therapist to address my specific needs.
- I understand that therapeutic massage is not a substitute for traditional medical treatment.
- I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional considerations based on my physical/emotional/psychological condition.
- I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly.

Client Signature		**Date:**	
Therapist Signature		**Date:**	

I would love to sign up to your newsletter and be contacted with all your practice updates ☐

GDPR May 2018:
The data collected on this form will be used for the sole purpose of clinical massage and will not be disclosed to any external sources. For insurance purposes these records shall be kept for at least 7 years following the last occasion on which treatment was given.