Client consultation form

Please complete before your first treatment. Your answers help your therapist treat you safely. All information is kept confidential.

1. Your details

Full name

Date of birth

Phone and email

Emergency contact (name and phone)

Doctor / GP (optional)

2. Health: do any of these apply to you now or recently?

- ☐ Fever, infection or feeling unwell today
- ☐ Blood clots / DVT, or on blood thinners
- ☐ Heart condition or pacemaker
- ☐ Skin conditions, rashes, cuts or bruises
- ☐ Varicose veins
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Recent surgery (last 6 months)
- ☐ High or low blood pressure
- ☐ Pregnancy (and how many weeks)
- ☐ Recent injury, sprain or fracture
- ☐ Cancer, or current cancer treatment
- ☐ Epilepsy
- ☐ Joint replacement or metal implants

☐ Allergies (oils, nuts, latex, fragrance)

☐ Back or neck problems

☐ Headaches or migraines

☐ Other condition or medication

If you ticked anything, please give details

Medication you take regularly

3. Your treatment

What would you like from the treatment (relaxation, tension, a specific area, sport or injury)?

Preferred pressure: light / medium / firm. Areas to avoid:

4. Consent

☐ I confirm the information above is correct and I will tell my therapist if anything changes.

☐ I consent to the salon keeping the health information on this form to provide safe treatment. I understand I can withdraw this consent and ask for the information to be deleted at any time.

☐ (Optional) I would like to receive offers and news from the salon by email or text. I can unsubscribe at any time.

Client signature and date

5. Therapist notes (salon use)

Treatment given, oils used, observations, advice given

Therapist name, signature and date

Data controller: [salon name, address, email]. We keep this form for [period] after your last visit. You have the right to access, correct and delete your data and to complain to the data protection authority (UK: ICO; Ireland: Data Protection Commission).