Sally Kelly - Massage Consultation Form

- **Your Full Name** *
- **Your Address** *
- **Email Address** * **Your Phone Number***
- **Your date of Birth** *
- **GP's Name** * **Practice Telephone** *
- **Do you suffer from any of the following:-**

High blood Pressure	**Low blood pressure**	**Nervous System Dysfunction**
Diabetes	**Epilepsy**	**Heart problems**
History of Thrombosis	**Pregnancy**	**Infectious conditions**
Cancer	**I.B.S**	**Skin Disorders**
Severe bruising	**Recent Haemorrhage**	**Severe varicose Veins**
Swellings / inflammation	**Recent Operations**	**Recent scar tissue**
Fractures and sprains	**Burns / sunburn**	**Painful muscles**
Any other condition		

Please list any current medication, include what treatment it is for *

I declare that to the best of my knowledge this information is correct *

All information is treated as strictly private and confidential