



Shiatsu, Reflexology and Thai Massage Health questionnaire

I advise you strongly to visit your GP prior to any treatments to put your mind at rest that there is not a serious health issue

All information is strictly confidential and will be kept on paper only.

Name				
e-mail:				
T:		M:		
Address:				
ICE contact;				
Age group: under 16 17-34 35-44 45-64 65+				
Have you had any treatments before? Yes/ No				
If yes, what type(s) and for how long?				
What is your main reason for wanting to have this treatment?				

Do any of these health conditions apply to you, if so please give brief details?

High blood pressure	Y / N	
Low blood pressure	Y / N	
Heart problems	Y / N	
Epilepsy	Y / N	
Diabetes	Y / N	
Arthritis	Y / N	
Asthma	Y / N	
Depression	Y / N	
Eye problems	Y / N	
Recent fractures or sprains	Y / N	
Operations	Y / N	
Hernia	Y / N	
Varicose veins	Y / N	
Back, knee or neck problems?	Y / N	
How many pregnancies	Y / N	
How are your periods?	Y / N	
What contraception do you use?	Y / N	

I take full responsibility for my health.

I will inform my practitioner of any medical changes.

Signed

Date

Thank you very much for filling in this form