MASSAGE CONSULTATION FORM

Aberdeen Chiropractic Clinic
your health & well being since 1979

Date: Practitioner: Service Type: Patient ID:

Name: Age: Date of Birth:

Address: Town: Postcode:

Tel: (Home): Tel: (Work) Mobile:

Email:

MEDICAL QUESTIONNAIRE

Do you suffer or have you ever suffered from any of the following?	☐	☐
Any back or neck injury?	☐ Yes	☐ No
Epilepsy?	☐ Yes	☐ No
High or low blood pressure?	☐ Yes	☐ No
Migraines?	☐ Yes	☐ No
Thrombosis or embolism?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No
Muscle spasms?	☐ Yes	☐ No
Dysfunction in nervous system?	☐ Yes	☐ No
Skin disorder?	☐ Yes	☐ No
Recent operations?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Are you on any medication?	☐ Yes	☐ No

If yes, please specify?

Name of GP Practice & Contact Number

PRIVACY POLICY CONSENT *Refer to our website for full policy wording* - **Please delete as appropriate:**

I consent / do not consent to Aberdeen Chiropractic Clinic using my contact information to send appointment reminders by telephone, email or SMS.

I consent / do not consent to receiving market information from Aberdeen Chiropractic Clinic

Signed: Date:

CONSENT TO MASSAGE

I consent to the Massage care offered or recommended to me by my Chiropractor or Massage Therapist. I intend this consent to apply to all present and future massages.

I understand that the information recorded in my files, or through any correspondence will remain in this clinic and will be treated with utmost confidence.

To be completed by parent or legal guardian if under 16 years of age:

Signed: Name (Please Print) Date: