



BOTANY MUSCLE THERAPY

Client Information Sheet



Thank you for taking the time to complete this information sheet. It will assist with your massage session.

All information is optional and will be treated confidentially.

Name:	DOB:
Address:	Phone:
Email:	
Occupation:	Mobile:

Current Conditions:

Headaches	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
Sleep Disturbance	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Inflammation	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	Hernia/Ulcer	<input type="checkbox"/>	Allergies	<input type="checkbox"/>
Breathing Problems	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>
Skin Problems	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>
Easy Bruising	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	OOS/RSI	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>		<input type="checkbox"/>
Numbness/Tingling	<input type="checkbox"/>	Cancer	<input type="checkbox"/>		<input type="checkbox"/>

Details of any conditions:
Sports / exercise undertaken:
Are there any body areas that are sensitive or that you would NOT like to have massaged? eg feet, head
Do you have any difficulty lying on your front or back?
What are your goals for the massage session? eg areas to massage, pressure, relaxation

Any loss of movement, painful movement, tension or cramps? Please indicate below.

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Email Snail Mail No thanks

You may experience mild discomfort, headaches or tiredness after the massage. This is a normal cleansing response to flushing waste products from muscles that have been tense. Please contact me if you have any severe or ongoing effects after the massage. Please consult your health practitioner if you have medical conditions that persist.

Please address any concerns or complaints firstly to this practitioner, or if not resolved to The Health and Disabilities Commission, P O Box 1791, Auckland.

Client Signature: _____ Date: _____