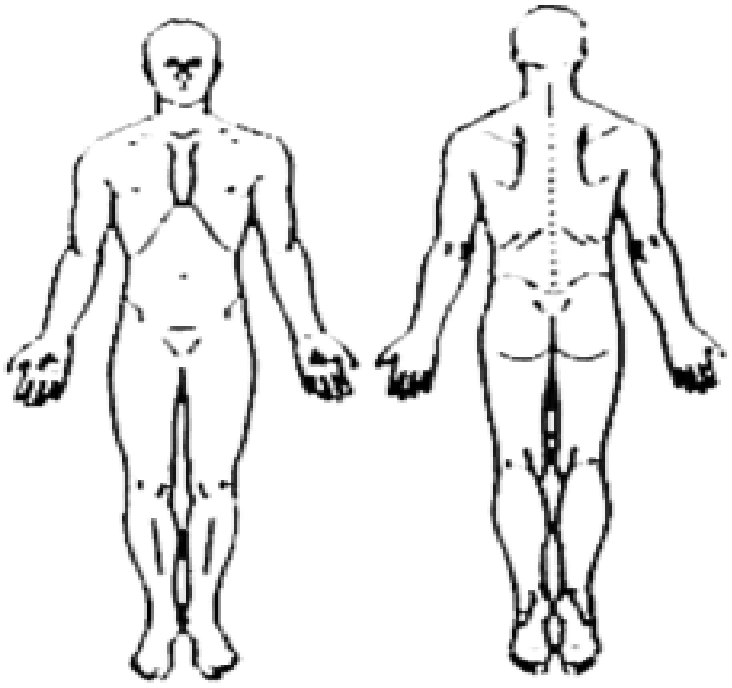
Cardea Massage Therapy Consultation form and Treatment Plan

Name:	Initial Assessment date:	DOB:
Address:	Phone number/s:	Email:
Male/Female:	Occupation/routine:	GP: last visit:
Marital Status:		
Smoking:		
Drinking:		
Past Medical History - previous operations, accidents, illnesses, health problems. e.g. Heart, diabetes, allergies, blood pressure.		
Medication:		
Sport, exercise, lifestyle, sleeping:		
Problem areas - reason for visit - history of injury:		



Somatype:
Body ratio:
Skin tone:
Muscle Tone:
Postural analysis/observations:

ROM Tests:

Palpation:
Aggravating:
Easing:
Assessment:
Treatment and date received:
Conclusion:

Recommendations	
Water:	
MET's - stretches:	
Cryotherapy:	
Thermotherapy:	
Soreness/bruising:	
Refer to doctor/chiropractor:	

Client Declaration

I confirm that all the information given during this consultation is accurate to my knowledge and I consent to receiving a body massage treatment.

Signature_ Date:

I confirm that I have been offered a consultation and postural analysis but have decided to decline the advice at the moment and will instruct the therapist of my requirements.

Signature_ _

Therapist's signature: Date:

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