

# Massage on Kells

New Client Form - Please note: The information on this form is kept strictly confidential

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_

Occupation: \_\_\_\_\_ Health Fund: \_\_\_\_\_

Email: \_\_\_\_\_

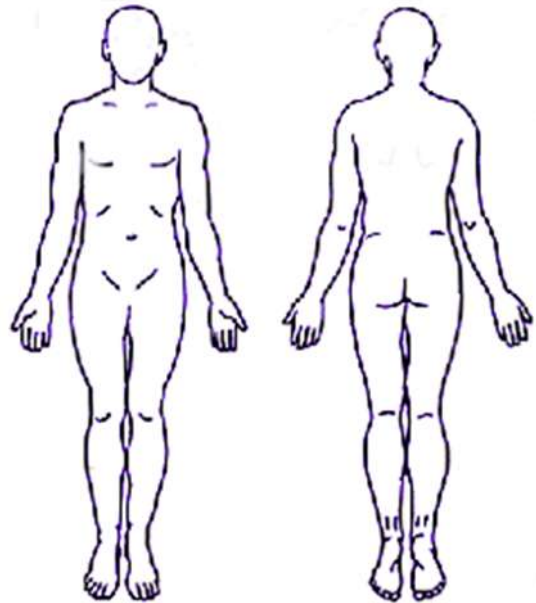
Is this your first massage? \_\_\_\_\_ How often do you have massages? \_\_\_\_\_

Reason for visit? \_\_\_\_\_

How did you find our clinic? \_\_\_\_\_

Have you had, or are you currently suffering from, any of the following?

- |                         |                          |                       |                          |
|-------------------------|--------------------------|-----------------------|--------------------------|
| Varicose veins          | <input type="checkbox"/> | Kidney ailments       | <input type="checkbox"/> |
| Headaches               | <input type="checkbox"/> | Shingles              | <input type="checkbox"/> |
| Depression              | <input type="checkbox"/> | Diabetes              | <input type="checkbox"/> |
| Neck/spinal injury      | <input type="checkbox"/> | Arthritis             | <input type="checkbox"/> |
| High/low Blood Pressure | <input type="checkbox"/> | Skin Disorders        | <input type="checkbox"/> |
| Cancer                  | <input type="checkbox"/> | Joint replacement     | <input type="checkbox"/> |
| Blood Clots             | <input type="checkbox"/> | Nervousness           | <input type="checkbox"/> |
| Osteoporosis            | <input type="checkbox"/> | Dizziness             | <input type="checkbox"/> |
| Herpes                  | <input type="checkbox"/> | Infectious conditions | <input type="checkbox"/> |
| Allergies               | <input type="checkbox"/> | Epilepsy              | <input type="checkbox"/> |
| Heart Ailments          | <input type="checkbox"/> | Loss of Balance       | <input type="checkbox"/> |
| Other                   | <input type="checkbox"/> | Numbness              | <input type="checkbox"/> |



Mark any area of pain or injury

Do you currently have any of the following?

Cold/flu/fever  Infection  Pregnancy

Are you currently under any medical or health care treatment, taking medication, or have you had recent surgery?

If so, please describe.....

Signature: \_\_\_\_\_ Date \_\_\_\_\_