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RELAX INDULGE ENJOY

## Consultation Form

### Personal Details

Name: Monica Chappell Address: 14 Vanderen Crescent  
Phone: (Home) \_\_\_\_\_ (Mobile): 0117966158 Email: monica@bigpond.com  
Date of Birth: 26/07/83 Do you know the time of your birth? \_\_\_\_\_ Location: England  
Occupation: Nurse Hobbies: crochet  
Next of Kin/Emergency Contact (Full Name): Ber Chappell Phone/Email: 0100203941

### Health Details:

Initial Reason for Treatment (relaxation, sports injury, muscle soreness etc.): muscle aches.  
Medication in use (for example, steroids, HRT etc.): amitriptyline, CBD, Lyrica.  
Are you Pregnant? N/A or Y/N Due Date \_\_\_\_\_

### Health Conditions/Symptoms – please tick

High/low blood pressure	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Other conditions (Please specify)
Cancer	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<u>Sciatic neuralgia.</u>
Respiratory conditions	<input type="checkbox"/>	Contagious skin conditions	<input type="checkbox"/>	
Heart Conditions	<input type="checkbox"/>	Recent Pregnancy	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	
Thyroid	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	
Thrombosis/Phlebitis	<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	
Digestive problems	<input type="checkbox"/>	Kidney/bladder	<input type="checkbox"/>	
Stress	<input checked="" type="checkbox"/>	Arthritis/rheumatism	<input type="checkbox"/>	
Emotional Problems	<input type="checkbox"/>	Menstruation Problems	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	
Insomnia	<input type="checkbox"/>	Hormonal Problems	<input type="checkbox"/>	
Migraine/Headaches	<input type="checkbox"/>	Fluid Retention	<input type="checkbox"/>	
Backache	<input type="checkbox"/>	Cellulite	<input type="checkbox"/>	
Other Conditions	<input type="checkbox"/>	Overweight	<input type="checkbox"/>	

### Lifestyle/Diet – please circle Y/N and describe details, if possible.

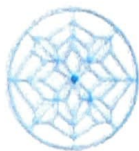
Smoking <u>Y/N</u> – how often?	<u>150g week</u>	PAST 12HRS (if applicable)	
Exercise <u>Y/N</u> – how often?	<u>daily walk</u>	Fever	<u>Y/N</u>
Alcohol <u>Y/N</u> – how often		Diarrhoea	<u>Y/N</u>
Water <u>Y/N</u> – how much per day?	<u>1 litre</u>	Vomiting	<u>Y/N</u>
Tea <u>Y/N</u> how much per day?		Contagious Illness	<u>Y/N</u>
Coffee <u>Y/N</u> – how much per day?	<u>6-8 cups.</u>	Under influence drugs/alcohol	<u>Y/N</u>
Vegetarian/Vegan <u>Y/N</u>		Others not mentioned	

### Formal Consent

I understand that the services received today, Massage Therapy, Beauty Therapy, I receive is provided for the basic purpose of relaxation, stress reduction and muscular tension and most important pure enjoyment. I further understand that the massage, skin treatment, and any other aspects relating to today's treatment should not be construed as substitute for medical examination, diagnosis, or treatment in any manner. The treatments performed today do not take the place of medical treatment where needed. If you are in doubt, please consult your doctor or physician.

Date: 27/7/21 Name: Monica Chappell Signature: [Signature]

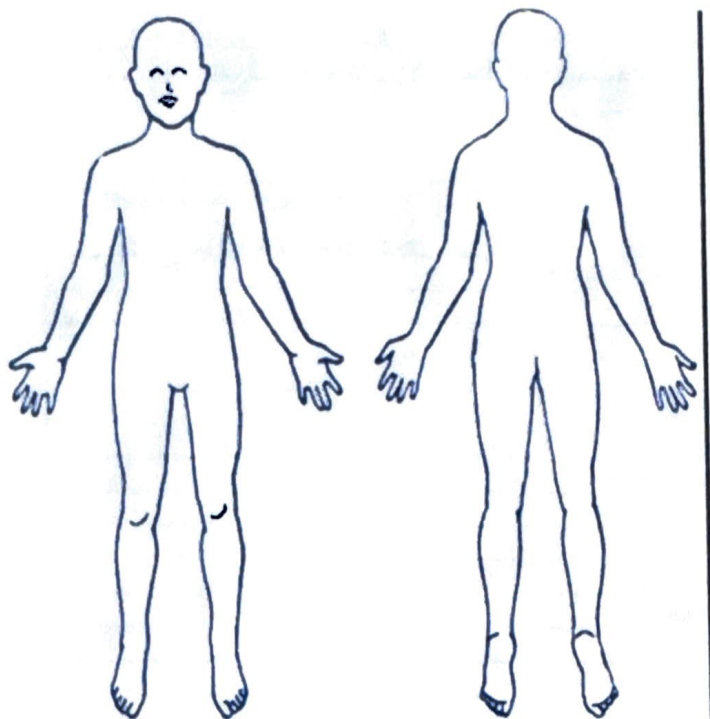




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RELAXATION • MASSAGE • THERAPY

**Physical Assessment (Office ONLY)**



**Main Observations(Office ONLY)**

DA - just tired needed  
to relax  
- nurse work up in room  
visiting family here in  
Perte

**Consultation Form – Notes (Office ONLY)**

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

31.7.21- Full body relaxation massage.

