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RELAX • INSPIRE • ENJOY

Consultation Form

Personal Details

Name: Rebecca Gannant Address: 92 Empire ave Wembley Downs
 Phone: (Home) _____ (Mobile): 0435 912 793 Email: rebeccagannant@outlook.com
 Date of Birth: 24/01/91 Do you know the time of your birth? — Location: Sobriaco
 Occupation: Business Hobbies: garden
 Next of Kin/Emergency Contact (Full Name): Patrick Phone/Email: _____
 Health Details:
 Initial Reason for Treatment (relaxation, sports injury, muscle soreness etc.): sore neck/shoulders
and relaxation
 Medication in use (for example, steroids, HRT etc.): _____
 Are you Pregnant? (N/A) or Y/N Due Date: _____

Health Conditions/Symptoms – please tick

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

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

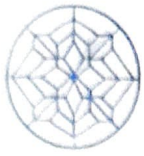
Smoking Y/N – how often?	Daily	PAST 12HRS (if applicable)	Y/N
Exercise Y/N – how often?	Daily	Fever	—
Alcohol Y/N – how often	most nights	Diarrhoea	—
Water Y/N – how much per day?	2 L	Vomiting	—
Tea Y/N how much per day?	—	Contagious Illness	—
Coffee Y/N – how much per day?	3-4 cups	Under influence drugs/alcohol	—
Vegetarian/Vegan Y/N	—	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: 24/3/19 Name: _____

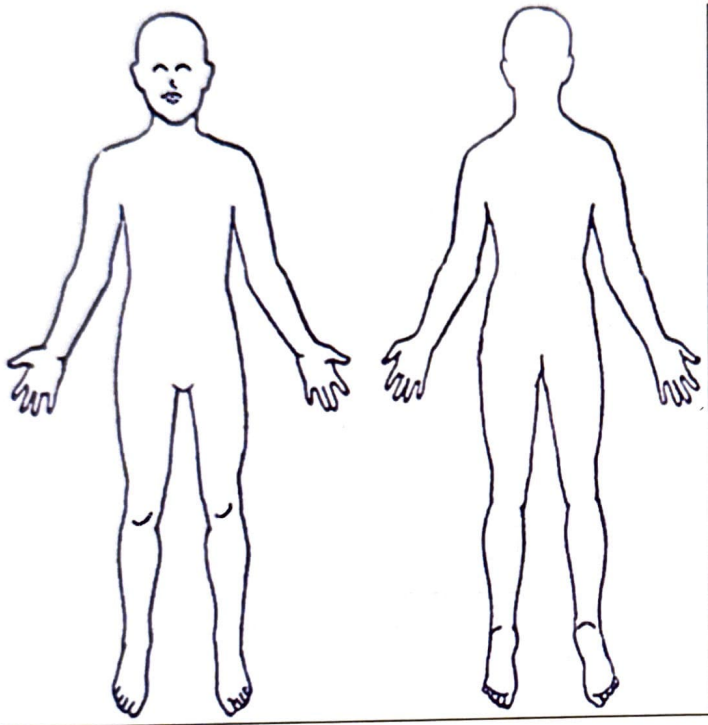
Signature: _____



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Physical Assessment (Office ONLY)

Main Observations (Office ONLY)



Consultation Form – Notes (Office ONLY)

Name: Rebecca Grant Address: 92 Empire Ave, Wembley Downs

28-3-19- 60min massage. C/o back, shoulders & neck.
TPT/DT upper body thoracic & neck focus on PSA, Rhomboids
&

