SUPERCALMING&HOLISTIC

Name:

DOB:

Occupation:

Address:

Phone Number:

Email:

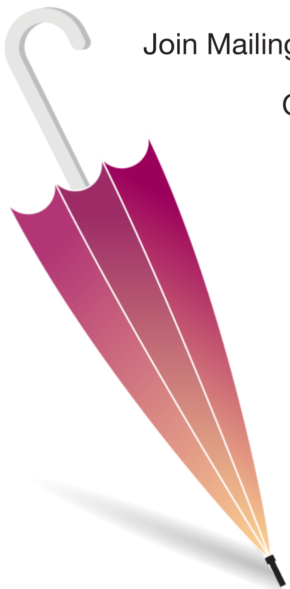
Emergency Contact:

GP Name & Number:

Voucher Code:

Join Mailing List:

Other:



CONTRAINDICATIONS:

Tick & list any conditions, diseases, disorders, & illnesses, infections you may have had.

Condition	Yes	No	Condition	Yes	No
Allergies	☐	☐	High/Low Blood Pressure	☐	☐
Arthritis	☐	☐	Injuries	☐	☐
Bacterial	☐	☐	Immune	☐	☐
Cancer/Chemotherapy	☐	☐	Medication	☐	☐
Contagious Skin	☐	☐	Mental Health	☐	☐
Deep Vein Thrombosis	☐	☐	Muscular	☐	☐
Diabetes	☐	☐	Nervous	☐	☐
Ears, Nose & Throat	☐	☐	Pregnancy	☐	☐
Epilepsy	☐	☐	Recent Operation/s	☐	☐
Fungal	☐	☐	Respiratory	☐	☐
Hair, Skin & Nails	☐	☐	Skeletal	☐	☐
Heart & Circulation	☐	☐	Uninary	☐	☐
Hormonal	☐	☐	Viral	☐	☐

List your ailemts here:

Please read the following and sign below:

I understand that the massage I receive is provided for the enhancement of mind, body and spirit. I am able to undertake massage without any adverse effects. I agree to inform the practitioner if I experience any discomfort or pain. I will keep the practitioner updated as to any changes in my medical status.
I understand that there shall be no liability on the practitioners part should I fail to do so.

Client Signature: Date:

Therapist Signature: Date: