Thank you for consulting with Louisa Carter Health.
In order to give you your ultimate massage experience and ensure the effectiveness and safety of your massage sessions, please fill this in to the best of your knowledge. Your input and feedback is valued before, during and at the end of the treatment to help in tailoring the massage to serve you in the best possible way.
This information will be treated with confidentiality.

Contact Details

Name: Date:

Postcode:

Phone:

Email:

Are you Pregnant? Yes No
If so, how many weeks are you? What is your due date?

Medical history

Please list any contraindications to massage that you may have, for example; high blood pressure, varicose veins, allergies etc:

List medications that you are currently taking, if any:

Have you got any areas of pain or tension that you specifically need extra work on?

What style of massage do you prefer?

Are you ok with Nut and seed oils to be used? Yes No

Do you have any allergies or aversions to essential oils? Yes No

Would you like to be on Louisa Carter Health mailing list? Yes No

Please turn over page for informed consent.

Louisa Carter Health Informed consent to massage therapy:

I, have chosen to consult with and hereby give consent for massage therapy to be provided by Louisa Carter Health.

I have provided a detailed medical history. I do not expect the therapist to have foreseen any previous or pre-existing condition that I have not mentioned. I understand that massage may provide benefits for certain conditions but results are not guaranteed. These benefits may include relief of muscular tension, relaxation, reduction in the symptoms of stress-related conditions and provision of general wellbeing. I also understand that massage therapy may produce side effects such as muscle soreness, mild bruising, increased awareness of areas of pain and light-headedness amongst other possible temporary outcomes. I understand that there some risks to massage therapy, including but not limited to, aggravation of preexisting symptoms. I am aware that the therapist does not diagnose illnesses, prescribe medications nor physically manipulate the spine or its immediate articulations.
The therapist understands that I have the right to question procedures used and to receive an explanation of any procedures that the therapist performs. I will tell the therapist about any discomfort I may experience during the therapy session and understand that the therapy will be adjusted accordingly.

I hereby request and consent to the performance of Massage therapy on me by Louisa Carter, and/or any other therapist working in this practice authorized by Louisa Carter.

I have read the above, and I have also had the opportunity to ask questions about its consent.
I intend this consent to cover the entire course of treatment. I understand that I am free to withdraw my consent and to discontinue treatment any time.

Client Signature (or Guardian's):

Therapist's Signature:

Date: