REVIVE

Massage & Beauty

Please take time to complete the Consultation Sheet

Name:	Date of Birth:	
Address:	Postcode:	
	Tel No:	
Email:		

Medical Information Please tick if any of the following apply:

- ☐ Migraines/headaches
- ☐ Heart conditions
- ☐ Asthma
- ☐ High/low blood pressure
- ☐ Skin sensitivity
- ☐ Diabetes
- ☐ Psoriasis
- ☐ Epilepsy
- ☐ Eczema
- ☐ Iodine sensitivities
- ☐ Acne
- ☐ Thyroid problem
- ☐ Hormonal imbalances
- ☐ Allergies (nuts etc)
- ☐ Renal or liver disorders
- ☐ Product allergies
- ☐ Pregnancy
- ☐ Joint problems
- ☐ Water retention
- ☐ Slipped disc
- ☐ Recent operation
- ☐ Muscular pain
- ☐ Depression
- ☐ General aches and pains
- ☐ Claustrophobia
- ☐ Poor circulation
- ☐ Other – please give details

Are you taking medication or supplement?

Is there anything else that you think we should know regarding your health which may affect or prevent you from having a treatment?

How did you hear about us?