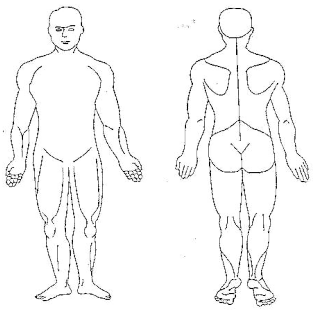
Penny Groom – Holistic & Remedial Massage Consultation

DATE: _____

PRIVACY NOTICE

1. The following information that you provide is not shared with anyone else. It is stored safely in this format. In the event that your medical information indicates that you can not undertake a massage and require another health professionals opinion or authorisation for treatment I will either advise you or gain your written consent to write a referral or letter of authorisation to the relevant person.
2. As of the date of signing this form the minimum legal requirement of information that my insurance company requires of you/me is; **YOUR FULL NAME, DATE OF CONSULTATION, & NOTES ON THE LIFESTYLE/MEDICAL HISTORY WHERE APPROPRIATE TO THE TREATMENT.** Along with this form I will keep notes on every treatment that you have with me.
3. It is a legal requirement by my insurance company to keep this information for **5 years** from your last appointment. After this date it will be disposed of by shredding or burning.
4. In the event that you provide your contact details and become a regular client they will be stored safely on my mobile and/or email contacts account for ease of identification. I will only use this information in regards to an appointment you have already made(reminder, cancellation or late arrival) or outstanding payments or in the event that you consent to receive any promotional information.
5. For any electronic data stored a strong password is created & changed regularly to protect from malicious hacking and the designated drivers WILL NOT be uploaded to any cloud based server. All data will be backed up frequently to prevent accidental deletion & data loss.
6. For those who booked online you can view the privacy notice detailed in section 8.
7. In certain circumstances, the data protection act allows personal data to be disclosed to law enforcement agencies without consent of the data subject. The company will ensure the request is legitimate, seeking assistance where necessary before disclosing information.
8. For further privacy information please visit www.pennygroommassage.co.uk or in your introductory leaflet.

Please mark ares of discomfort/problem areas.



OPT IN

In accordance to insurance policies, offer professional courtesy and provide the best treatment it is good practice to contact your healthcare provider to discus certain ailments that you disclose to me. If you are happy for me to do this now or in the future please tick the box. ☐

I often contact regular clients with future availability prior to busy periods to offer them the first opportunity to book an appointment. ☐
If you are happy with me contacting you in this way please tick the box

I may also send out information detailing new services/products. If you are happy for me to contact you in this way please tick the relevant boxes.
Phone ☐ **Email** ☐ **Mail** ☐

Prior to contacting your health care professional your consent will be asked again. You have the right to withdraw consent from being contacted by Penny, at any time reply STOP or mail panngroom@yahoo.com.

Personal Details

***Full Name**:_____

Home Address:_____

_____

DOB:_____

Telephone: _____

Email:_____

Emergency Contact Name & Number_____

_____

Doctors Name, Contact Number & Address_____

_____

Alternative Therapist Name, Contact & Address_____
(inc Physio, Homeopath, Acupuncturist, Osteo, Chiro etc)

_____

***Required information**

List of Medication:_____

_____

*Are you or do you Suffer any of the following

. Fungal Infection
. Cold sores
. Infectious/Contagious conditions
. Diabetes
. Cancer
. Epilepsy
. Osteoporosis
. Nervous Dysfunction
. Varicose Veins
. Cerebral Palsy
. Stroke
. Heart Conditions
. Allergies
. Diagnosed Back Conditions
. High or Low Blood Pressure
. Arthritis (Osteo/Rhematoid)
. Respiratory Conditions
. Skin Conditions
. Bone or Joint Conditions
. Trapped or Pinched Nerve
. Recent Sprains or Strains
. Recent Operations (2 years or less)
. Recent Steroids or Cortisone Injection
. Any Swelling/Inflammation
. Embolism, Thrombosis, Aneurism
. Recent Invasive facial treatments
. Other old injuries

Other_____

Please give details to those circled above. i.e area affected, type, date of injury/operation etc any rehab.

_____

_____

_____

_____

_____

_____

_____

Please make your therapist aware of all Verucca's, Warts, Cold Sores, Althletes foot or fungal/contagious infections. If in specific areas only please ensure areas are well covered for hygiene purposes.

*Life Style

1.) Out of 24 hrs how much time do you spend;

Sitting____Standing___Travelling _____Walking _____Exercising____Sleep___

2.)What musculo-skeletal issues do you have:
a) Back b) Joint Stiffness c) Aches/pain d) Headaches

3.) When do you feel more discomfort:
a)In bed b) First thing in the morning c) During the day
d) End of the Day

4.) Does the discomfort arise when you do the following:
a) Sitting b) Standing c) Laying
d) Doing a particular movment

_____

e) Staying in a particular stance

_____

5.)What execise do you do:
a) Walking b) Running c) Racket Sport d) Contact sport e) Yoga f) Pilates g) Weights

Other or more specific _____

6.) How stressed are you at:
Work _____ Home _____ (1-Not at all, 10-Extremely)

*Women Only

Are you pregnant? **Y / N**

. Anaemia
. Oedema or Swelling
. Headaches
. Leg cramps
. Nausea
. Rectus muscle separation
. Excess Thirst
. Constipation
. Breathlessness
. *vaginal bleeding
. *Uterine Bleeding
. *Abdominal cramping
. *Placenta Problems
. *Pre-eclampsia

If YES have you or have you ever had:

. Gestational Diabetes
. Fatigue
. Insomina
. Heart Burn
. Sciatica
. Symphysis pubis separation
. Previous Caesarian birth
. Morning Sickness
. *Leaking amnionic fluid
. *Bladder infection
. *Chronic Hypertension
. *Miscarriage
. *Pre-term Labour
. *Visual Disturbances

Due Date_____ Weeks pregnant _____

I am experiencing **a low/high** risk (circle one) pregnancy according to my doctor/midwife.

If I am currently having or develop complications (any conditions/symptoms listed above with *) I will discuss the condition with my massage therapist, and will have a medical release for massage signed by my pre-natal care provider before continuing bodywork.

Post massage your body will be rebalancing itself and trying to eliminate an increased amount of waste. Therefore it is advised to do the following to aid this process by doing the following;

· ***Make time to relax***
· ***Drink plenty of water***
· ***Avoid Alcohol for 24 Hours***
· ***Cut down on smoking***

Occasionally, you may experience reactions when the body begins its self-healing process and elimination of toxins. These reactions may include:

· ***Frequent visits to the toilet***
· ***Runny nose and/or cough***
· ***Slight Rash as the skin rebalances***
· ***Perspiration – another way that the body can excrete waste***
· ***Deep sleep or difficulty sleeping and vivid dreams***
· ***Conditions which have been suppressed may flare up temporarily before they heal***

Reactions are only temporary and should clear within 24-48 hours. They are positive signals that your body has responded to the treatment and is balancing itself.

Disclaimer

Guardians of under 16 year olds;

I am aware that participation in the treatment is voluntary. As a guardian of the named person above I give consent to them undertaking a massage and understand that by law they require a chaperone and must not be left alone at anytime**. If providing details I have also provided a guardians contact rather than the childs.**

For my records, I need to confirm that you have read, understood and answered all of the previous questions. If there is anything you do not understand, please ask. Otherwise please read the following and sign below.

To the best of my knowledge, the information I have given is true, and I have not withheld any information concerning my health. I will keep my therpist updated on my health should there be any changes to answers given. I understand there is a possibility I may experience some minor reactions as my body adjusts to the treatment. I understand that the therapist does not diagnose illness, disease or any other physical or mental condition. I understand that this treatment is not a substitute for medical examination, diagnosis or treatment. While I recognise that all due care will be taken by the therapist, I am aware that my participation in the treatment is voluntary.

(Adult or Guardian) Signed:_____ **Date:**_____

(Adult or Guardian) Name Printed:_____

How did you here about me? **Recommendation (who)**_____

Internet_____

Referral (who)_____

Event (where)_____

Other_____