

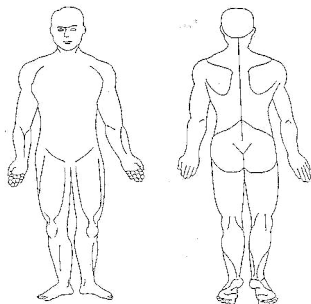
# Penny Groom – Holistic & Remedial Massage Consultation

**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, gain your written consent to write a referral or letter of authorisation to the relevant person or sign a disclaimer form.
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 in paper format.
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. Your details will be backed up up frequently to prevent accidental deletion & data loss.
5. For any electronic data stored a strong password is created to protect from malicious hacking and the designated drivers WILL NOT be uploaded to any cloud based server.
6. 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.
7. For further privacy information please visit [www.pennygroommassage.co.uk](http://www.pennygroommassage.co.uk) or in your introductory leaflet.
8. A copy of your retained data may be requested from Penny Groom

**Please mark areas of discomfort/problem areas.**



**List of Medication:** \_\_\_\_\_

## 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 discuss 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](mailto: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**

**\*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, Athletes 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:** Rate discomfort 1-10 (10 excruciating)

- 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:** Rate discomfort 1-10 (10 excruciating)

- a) Sitting                      b) Standing                      c) Laying  
d) Doing a particular movment

e) Staying in a particular stance  
\_\_\_\_\_

**5.)What excise 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)

**EXPECTATIONS OF MASSAGE (Tick as many as required)**

- Relaxation
- Muscle Tension relief
- Other  \_\_\_\_\_

**\*Women Only**

Are you pregnant? **Y / N**

**If YES have you or have you ever had:**

- |                            |                              |
|----------------------------|------------------------------|
| . Anaemia                  | . Gestational Diabetes       |
| . Oedema or Swelling       | . Fatigue                    |
| . Headaches                | . Insomina                   |
| . Leg cramps               | . Heart Burn                 |
| . Nausea                   | . Sciatica                   |
| . Rectus muscle separation | . Symphysis pubis separation |
| . Excess Thirst            | . Previous Caesarian birth   |
| . Constipation             | . Morning Sickness           |
| . Breathlessness           | . *Leaking amnionic fluid    |
| . *vaginal bleeding        | . *Bladder infection         |
| . *Uterine Bleeding        | . *Chronic Hypertension      |
| . *Abdominal cramping      | . *Miscarriage               |
| . *Placenta Problems       | . *Pre-term Labour           |
| . *Pre-eclampsia           | . *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.

**Before Treatment:** Discuss any new or existing conditions. Discuss if you'd like specific areas paid attention to or not. Anything you did or did not like about previous massages and your expectations of massage. This will help improve your treatment and future treatments. Ask any questions that you may have about the treatment.

**During Treatment:** Make sure you are comfortable during the treatment. Talk to your therapist, you are in control of the treatment. Do you need extra/less cushions or cushions moved (you should be in a position that you can fully relax in). Move if you need to move. Is the pressure too deep or not deep enough. If you don't like a technique or feel uncomfortable ask the therapist to stop. Some techniques may feel deeper (Soft Tissue Release, S.T.R & Neuromuscular Technique N.M.T), try and relax through them by deep breathing and letting go as you breath out, the discomfort should decrease. If it stays the same or increases let the therapist know. The therapist will discuss this prior and during your massage. The more massages you have and better rapport you have with the therapist the better you will be able to communicate and understand each others body language and expectations.

**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 . Muscle soreness . Drowsiness . Mild bruising · 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.

If you have any reaction that concerns you or lasts longer than expected please contact me for further advice.

### 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 therapist 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  Other

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