Listen to Feel (Amy Rogers)

Patient Information Questionnaire

CLIENT NAME…………………………………………………………………………….…………..…………

DATE OF BIRTH ………………………………………………………………………..………………………..

ADDRESS ……………………………………………….………………………………………………………  
POSTCODE ……………………………………………………………………………………………...……….

MOBILE NUMBER ……………………………………………………………………………………………….

E-MAIL ADDRESS ……………………………………………………………………………………….………

OCCUPATION……………………………………………………………………………………………………..

Please seek GP / specialist advice and get written permission prior to the Indian Head Massage if you have any of the following -

ACUTE RHEUMATISM

ASTHMA

CANCER  
CARDIOVASCULAR CONDITIONS

HIGH OR LOW BLOOD PRESSURE

DIABETES  
EPILEPSY

RECENT OPERATION

OSTEOPOROSIS

NERVOUS SYSTEM DYSFUNCTION

MEDICAL OEDEMA

SPINAL CONDITIONS

ANY OTHER CONDITION CURRENTLY BEING TREATED

CURRENTLY TAKING PRESCRIBED MEDICATION

Please be aware that if you have any of the conditions below, I **cannot** carry out an Indian Head Massage on you -

FEVER

FIRST 3 MONTHS OF PREGNANCY

RECENT ACCIDENTS, INJURIES OR SURGICAL INTERVENTIONS

ACUTE INFECTIOUS DISEASES (EG. FLU, CHEST INFECTION)

LOCAL INFECTIOUS AND / OR SKIN DISORDERS

INFLAMMATION AND SWELLING

RECENT WHIPLASH

PLEASE SIGN TO AGREE THE ABOVE INFORMATION IS CORRECT:

**CLIENT SIGNATURE** ……………………………………………………… **DATE** ………………………

GP Letter

GP Address

Date

Client

Dear Dr.

…………………………………… has informed me that you are their General Practitioner and as a matter of standard practice, I am writing to you in connection with the matters set out below.

I would be grateful if you could confirm whether or not the proposed complementary treatment should be given. Alternatively, please call me to discuss any modifications that you feel are necessary.

Your cooperation in this matter would be much appreciated.

Yours faithfully,

Amy Rogers

**Treatment requested by client:** Indian Head Massage

**Client condition:**

Medical consent given?

Yes - Any modifications to treatment?

No

Signed:

Date: