Safeguarding and Consent Form- inclusive all treatments, including Deep Tissue Massage, Cupping, Therapeutic Massage and Acupuncture procedures.

Full Name:

Address:

Usual GP (and practice):

Date of Birth:

Mobile:

Email address:

Emergency contact name:

Relationship to you:

Contact Number:

Dear Participant,

This written consent form covers any and all treatments that you participate in with the therapist at Kindred Space clinic, Therapia Road, East Dulwich, from the initial assessment appointment through to any and all additional follow up treatments and will be reviewed at six monthly intervals. Verbal consent will be requested from the client throughout each session in line with individual treatment. These consents are in line with current safeguarding guidelines.

The treatment given will vary depending on the individual needs of the client and may include any of the following techniques: deep tissue massage, therapeutic massage, hot stone massage, cupping and acupuncture. You may find some of these techniques uncomfortable; the intensity of the techniques can be altered to suit your comfort level so please let the therapist know if at any time you wish the intensity to change or the treatment to stop. Should you prefer not to receive any of a particular kind of treatment, please let the therapist know before commencement of the massage or at any time during the massage.

All treatments can involve massaging different parts of the body as relevant to the client's needs and wishes, excluding contraindicated areas and the genitals. The parts of the body not being massaged will be covered and kept warm and only uncovered areas of the body will be massaged. Female clients must wear sports shorts and a sports bra for all treatments. For female clients who wish to remove their sports bra for the purposes of Deep Tissue Massage only, this must be explicitly requested by the client, and the signing of this form indicates the client's express permission for the removal of upper body clothing in this instance. If at any time the client is uncomfortable with the massage, please inform the Therapist and the massage will be discontinued.

The physical response to soft tissue work varies and cannot always be predicted as every individual is different. There is no guarantee that the treatment given will help the condition you are seeking treatment for and there is a risk that any treatment will cause some discomfort or aggravation of the existing condition in the short term. Every effort will be made to minimise these risks by evaluation of preliminary information relating to your health and fitness and by seeking feedback to each different element of treatment as it is introduced.

By signing below:

- You acknowledge that you have read and are happy with all of the above
- You agree that the health information you have provided on the health questionnaire is accurate and complete to the best of your knowledge.
- You have no knowledge of anything that may contraindicate the use of massage on your body.
- You explicitly consent to the processing of the personal and sensitive data you have included in this and the health questionnaire form and from any interactions with the therapist thereafter, in accordance with the therapist's Privacy Policy (available on request).
- You acknowledge that signing of this form, covers attendance at any subsequent session(s) , is taken as consent for that session.

Name: …… **Signature**: ……. **Date**: ……..

Health Questionnaire

Area / Problem to be addressed:

.....

What other sports / fitness activities (if any) do you regularly do?

.....

Pain at night **Y / N** Unexplained weight loss **Y / N** Night sweats **Y / N** Coordination or balance changes **Y / N**

If **yes** to any of the above, please give details: .....

……..

General Health	**Yes**	**No**	**Details:**
Do you have an underactive / overactive **thyroid**? (or take thyroxine?)	□	□	.....
Do you have any **heart** / **blood pressure** (high / low) problems?	□	□	.....
Do you have **angina** or have a little spray for when you get chest pain?	□	□	.....
Do you have a history of **rheumatoid** or **osteo**arthritis?	□	□	.....
Have you or a member of your family ever been diagnosed with **cancer**?	□	□	.....
Have you ever been told you have reduced bone density / '**osteoporosis**'?	□	□	.....
Are you **epileptic**? If so, when was your last fit?	□	□	.....
Are you **diabetic**? If so is this well controlled or variable?	□	□	.....
Are you **asthmatic** or have any other respiratory problems eg. **COPD**?	□	□	.....
Are you currently taking, or have taken for more than 6 months, any **steroids**?	□	□	.....
Are you on any blood thinners? eg. **warfarin** / aspirin	□	□	.....
Have you had any **surgery** in the last year (or relevant surgery before this)?	□	□	.....
Have you ever had any **spinal surgery** / procedures or **joint replacements**?	□	□	.....
Have you **broken** / **fractured** any bones in the last year?	□	□	.....
Do you suffer from any regular **aches** / **pains**?	□	□	.....
Do you suffer from **pins and needles** / **numbness** in your arms or legs?	□	□	.....
Are you **allergic** to latex? (Or have any other allergies?)	□	□	.....
Are you generally in good health?	□	□	.....
Could you be **pregnant** or have you **given birth** in the last **6 months**?	□	□	.....
Do you drink? If so, how many units (roughly) per week?	□	□	.....
Do you smoke? If so, how many per day?	□	□	.....
Are you able to **comfortably get into** and **maintain** the following **positions**?: hands and knees, lying on your back, lying on your front and kneeling	□	□	.....

Other **Medical issues** / **aches and pains** (not covered above / further details):

.....

What **medication** are you taking, if any?:

…….....

Name: Signature: Date: