



INDIAN HEAD MASSAGE – CONSULTATION FORM

Date of consultation.....Client code.....

Name.....Occupation.....

Address.....Tel. No.....

E-mail.....Date of birth.....

Medical History Checklist:

- Any recent head or neck injury Yes No
- Severe bruising in treatment area Yes No
- Epilepsy Yes No
- Recent haemorrhage Yes No
- Low or high blood pressure Yes No
- Migraines/ Headaches Yes No
- Thrombosis or embolism Yes No
- Diabetes Yes No
- Spastic conditions Yes No
- Dysfunction of the nervous system Yes No
- Skin disorders Yes No
- Scalp infections Yes No
- Cuts or abrasions in treatments area Yes No
- Recent operations Yes No
- Arthritis of the upper spine Yes No
- Osteoporosis Yes No
- Allergies Yes No
- Cancer Yes No

Is GP referral necessary? Yes / No

Current medication.....

Is your general health.....good / average / poor

Clients Lifestyle:

Energy levels.....high / average / poor

Stress levels.....high / average / poor

Emotional state.....

Do you find time to relax?Any hobbies?

INDIAN HEAD MASSAGE – TREATMENT SHEET

Treatment plan / Objectives:.....
stress relief / relaxation / relief from tension
/psychological uplift improved lymphatic drainage /
improved scalp circulation improved muscle tone /
improved hair condition

Body parts massaged: scalp / head / face / neck / shoulders / upper back / arms

Techniques used: effleurage / petrissage / tapotement / frictions /
pressures

Medium used: none / oil: state which oil used:

Clients psychological response: nervous / relaxed / other

Client range: Age:.....Sex:.....
Hair Type:.....
Small build / average build / large framed

Outcome of Treatment: stress relief / relaxation / effective treatment / non-
effective treatment improved lymphatic circulation /
improved circulation in scalp improved muscle tone /
improved hair condition / psychological uplift

After care advice given:
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.....

Therapist’s Evaluation:
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.....

Future Treatment Recommendations:
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.....

Client to sign and comment on success of treatment:
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.....
.....

Client declaration

I declare the information I have given is correct. I have been fully informed about
contraindications and as far as I am aware can proceed with treatment.

Client Signature.....Date.....

DATE _____

TECHNIQUES APPLIED

DURATION

FUTURE TREATMENT

RECOMMENDATIONS

RESPONSE FROM CLIENT

DATE _____

TECHNIQUES APPLIED

DURATION

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RECOMMENDATIONS

RESPONSE FROM CLIENT