Consultation Sheet

Full Name:……
Address:……
……
……..
DOB:……
Contact Telephone Number:……..Mobile:……..
Email Address:……..

Doctors Name:……
Address:……
……
Telephone Number:…….

Are you suffering from any of the following?:
(Please circle your answer if yes.)

Varicose Veins
Thrombosis/ Blood Clots
Skin Disorders (e.g. Eczema, Dermatitis, Psoriasis)
Allergies (e.g. food, skin, respiratory)
Sprains/ Fractures
Blood Pressure problems (low or high)
Urinary infections/ Disorders (e.g. cystitis, thrush)
Headaches/ Migraines
Heart Conditions (e.g. pacemaker, metal pins)
Muscle Spasticity
Diabetes
Epilepsy
Kidney or Liver Disorders
Blood Disorders (e.g. thrombosis, phlebitis)
Nervous Disorders (e.g. insomnia, nervous tension, depression, worrier)
Hepatitis/ HIV/ AIDS
Gynaecological Problems
Recent Operations

If yes, please give details:…….....
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……..
……
……..
……
……..

Are you pregnant/ breast feeding? Yes/ No

Lifestyle:

Daily water intake:……
Weekly Alcohol Intake:…….
Daily Tea/ Coffee Intake:……
Smoker (frequency):……
Medication:…….
Receiving other alternative therapies:…….
Hobbies/ Exercise:……
Energy Levels (1 is low, 10 is high):……..
Stress Levels (1 is low, 10 is high):……
Do you eliminate any foods:…….

Skin Type/ Posture Analysis:

Areas of pain or tension:…….
Posture problems: Kyphosis/ Lordosis/ Scoliosis/ Dowagers Hump/ Flat feet
Muscle Tone: Weak/ Average/ Poor
Circulation: Good/ Average/ Poor
Weight: Underweight/ Ideal/ Overweight
Skin Type: Oily/ Combination/ Dehydrated/ Normal/ Mature/ Sensitive/ Dry

Record:

Treatment Description/ Details:…….....
……
……
……..

Aftercare Advice Details:……..
……
……
……
……..

I confirm that all the information I have provided on this form are correct. I take full responsibility for the treatment I am about to receive. I have not withheld any information that may be relevant to my treatment.

Client Signature:…….

Date of Consultation:……