

## 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:.....  
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.....  
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**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.**

☐

I agree to receiving marketing updates on your services by email.

Client Signature:.....

Date of Consultation:.....