Consultation Sheet

Full Name:……
Address:……
……
……..
DOB:…….Marital Status:…….Children/ Ages:…….
Contact Telephone Number:…….Occupation:……
Email Address:……..

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

Have you ever suffered from or are suffering from any of the following?:
(Please circle your answer if yes.)

Varicose Veins/Thrombosis/ Blood Clots
Any Infection, Disease or Fever
Diarrhoea or Vomiting
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/ Under or Over Active Thyroid
Heart Conditions (e.g. pacemaker, metal pins)
Cancer/ Melanoma, Diabetes, Epilepsy, Muscle Spasticity
Kidney or Liver Disorders
Blood Disorders (e.g. thrombosis, phlebitis)
Nervous Disorders (e.g. insomnia, nervous tension, depression, worrier)
Hepatitis/ HIV/ AIDS
Gynaecological Problems
Undiagnosed Lumps
Oedema or Fluid Retention
Recent Operations

If yes, please give further details of the above or any other diagnosed conditions:……
……
……..
……
……..
……
……..

Are you menstruating? Yes/ No
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 or inflammation:…….
Height:……Weight:……..
Posture problems: Kyphosis/ Lordosis/ Scoliosis/ Dowagers Hump/ Flat feet
Muscle Tone: Good/ 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:……
……
……
……
……..

I confirm that all the information I have provided on this form is 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:……