|  |  |
| --- | --- |
| Mr/ Mrs/ Miss/ Ms/ Other |  |
| Forename: |  |
| Surname: |  |
| Address: |  |
|  |  |
| Postcode: |  |

**Client Details**:

Client Consultation Form

|  |  |
| --- | --- |
| Mobile: |  |
| Home Telephone: |  |
| Email: |  |
| Date of Birth: |  |
| Occupation: |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Piercings/Tattoos |  | Epilepsy |  | Diabetes |  | Thrombosis/DVT |  | Allergies |
|  | Cancer |  | Sensitive Skin |  | Claustrophobia |  | Surgery past 6 months |
|  | Prosthetics |  | High/Low Blood Pressure |  | Depression/anxiety |  | Skin Infections |
|  | Heart Conditions |  | Varicose Veins |  | Pregnancy |  | HIV/AIDS |
|  | Intolerance to heat |  | Hepatitis |  | Eczema/psoriasis |  | Fungal Infections /Athletes foot |

If you have ticked any of the above please explain in more detail:

**Lifestyle Questionnaire: Medications: What do you take and why?**

|  |  |
| --- | --- |
| Yes | No |
|  |  | Is your sleep disturbed? |
|  |  | Do you smoke? |
|  |  | Are you taking any medication? |
|  |  | Are you breastfeeding? |
|  |  | Do you exercise regularly? |
|  |  | Is there any history of family illness? |

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Please Provide details of any other health issues that you feel may be relevant.

**Body Treatments:**

Treatment aims (select what applies)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Relaxation & Stress Relief |  | Treat painful muscles or joints |
|  | Relieve tired or aching muscles |  | Reduce water retention |

**Adding your name and date to this form acts as an electronic signature and confirms that:**

* **Information was provided voluntarily and you agree to it being kept confidentially on file.**
* **Is a complete, accurate record of my past and current state of health.**
* **I agree not to stop any medications/ treatment prescribed my doctor.**

|  |  |  |  |
| --- | --- | --- | --- |
| Client Signature: |  | Therapist Signature: |  |
| Date: |  | Date: |  |

**Client History**

Please indicate if anything has changed medically since your last treatment:

|  |  |  |
| --- | --- | --- |
| Date | Treatment | Signature by client to confirm nothing has changed. |
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