# Client Consultation Form

**Client Details**:

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

| 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:**

| 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? |

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

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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