

**CONSULTATION FORM – NEW CLIENTS**

|  |  |
| --- | --- |
| Full Name |  |
| Full Address |  |
| Date of Birth |  |
| Email Address |  |
| Mobile Number |  |
| Doctor Surgery & Address |  |

Are you happy to receive offers and promotions via email and text? **YES/NO**

Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main focus for the treatment:  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Are you on any medication: **YES/NO**   
  
If YES, please list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| **Anaysis** | **Precautions and contra-indications** |
| Occupation | Diabetes Yes/No |
| Smoker | Epilepsy Yes/No |
| Diet | Heart conditions Yes/No |
| Exercise | Recent head or neck injury Yes/No |
| Stress 1-10 | Severe Bruising Yes/No |
| Energy 1-10 | History of thrombosis Yes/No |
| Sleep | Skin disorders or infections Yes/No |
| **General health** | Chronic ME Sufferer Yes/No |
|  | Cuts/abrasions to local area Yes/No |
|  | Could you be pregnant Yes/No |
|  | Recent haemorrhage Yes/No |
|  | Allergies Yes/No |
|  | Nervous system dysfunction Yes/No |
|  | Cancer Yes/No |
|  | High or low blood pressure Yes/No |
|  | Headaches/migraines Yes/No |
|  | Osteoporosis Yes/No |
|  | Oedema Yes/No |
|  | Lymphedema Yes/No |
|  | Depression/anxiety Yes/No |

**Declaration: - I certify that the above statements are true and correct and that I have been fully informed and advised of the treatment to be undertaken. I agree to the treatment offered by the therapist and have obtained consent from my doctor or specialist when necessary.**

**Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**