Client Consultation Form

Client Name: **Address:**

DOB:

Profession:

Tel. No's:

CONTRAINDICATIONS requiring medical permission – *in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment (select where appropriate)*

Pregnancy	□	Dysfunction of the nervous system	□
Cardiovascular Conditions	□	Bells Palsy	□
Haemophilia	□	Trapped nerve	□
Medical oedema	□	Condition treated by a GP/therapist	□
Cancer	□	Inflamed nerve	□
Osteoporosis	□	Postural deformities	□
Arthritis	□	Spastic conditions	□
Nervous/Psychotic condition	□	Whiplash	□
Epilepsy	□	Slipped disc	□
Recent Operations	□	Undiagnosed pain	□
Diabetes	□	When taking prescribed medicine	□
Asthma	□	Acute rheumatism	□
Kidney infection	□	None of the above	□

CONTRAINDICTIONS that restrict treatment:

Completely restricted		***Partially restricted***	
Fever	□	Cuts, bruises and abrasions	□
Contagious or infectious disease	□	Sunburn, vertigo, earache	□
Under the influence of drugs or alcohol	□	Hormonal implants, Tinnitus	□
Diarrhoea and vomiting	□	Localised swelling, migraine	□
Conjunctivitis	□	Gastric ulcers, Inflammation	□
Pediculosis Capitis	□	After a heavy meal	□
Sycosis Barbae	□	Adhesive capsulitis, headache	□
Partially restricted		Hernia, anaphylaxis	□
Skin diseases	□	Recent Fractures # (3 months)	□
Undiagnosed lumps and bumps	□	Cervical spondylitis	□
Varicose veins	□	Scar tissue (2 yrs major op' 6 mths	
Pregnancy (abdomen)	□	small scar)	□
Conditions affecting the neck	□	None of the above	□

PERSONAL INFORMATION

Lifestyle: Active □ Sedentary □

Muscular/Skeletal problems: Back □ Aches / Pains □ Stiff Joints □ Headaches □

Circulation problems: Heart □ Blood Pressure □ Cold hands/Feet □ Varicose veins □

Gynaecological / Urinary system: Irregular period's □ PMT □ Menopause □ HRT □ Coil □

Nervous / Endocrine system: Migraine □ Tension □ Stress □ Depression □

Lymphatic / immune system: Fluid retention □ Cellulite □ Prone to infections □ Sore throats □ Colds □ Chest □ Sinuses □

Do you suffer/have you suffered from: Dermatitis □ Acne □ Eczema □ Psoriasis □ Allergies □ Hay fever □ Asthma □ Skin cancer □

Regular antibiotic/medication taken? Yes □ No □ If yes, which ones?
Herbal remedies taken? Yes □ No □ If yes, which ones?
Ability to relax: Good □ Moderate □ Poor □
Sleep patterns: Good □ Poor □ Average No. of hours?
Do you see natural daylight in your workplace? Yes □ No □
Do you work at a computer? Yes □ No □ If yes how many hours?
Do you eat regular meals? Yes □ No □
Do you eat in a hurry? Yes □ No □
Do you take any food / vitamin supplements? Yes □ No □ If yes, which ones?
Do you suffer from food allergies i.e. nuts Yes □ No□
Do you smoke? Yes □ No □ How many per day?
Do you drink alcohol? Yes □ No □ How many units per day?
How often do you exercise? Never □ Occasionally □ Irregularly □ Regularly □ Types:
What is your skin type? Dry □ Oily □ Combination □ Sensitive □ Dehydrated □

How high are your stress levels: Home: 1–10 Work: 1-10 (10 being the highest)

Any other information you consider relevant:

Reason for treatment?

Consent to treatment

I confirm that the information I have given is correct and that I will advise of any changes if and when they occur.

I can confirm that:
(a) I have received GP verbal consent for this contraindication
(b) I have been informed and understand the implications of this contraindication and wish to proceed with this course of treatment.

Clients Signature: Date: