|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Your  | phone | WhattsApp | Messenger | Email |
| Preferred method of contact details |  |  |  |  |

How do you regard your general health & lifestyle?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Good  | Average | Poor |
| Health |  |  |  |
| Weight |  |  |  |
| Energy levels |  |  |  |
| Stress levels |  |  |  |
| Ability to relax |  |  |  |
| Sleep pattern |  |  |  |
| Diet |  |  |  |
| Alcohol Tobacco Intake |  |  |  |
| Fluid Intake |  |  |  |
| Muscle tone |  |  |  |

Exercise: Daily Weekly Occasionally Never

Do you suffer with

Depression

Anxiety

Diagnosed MH

Please give more info below if happy to do so

Surgery/GP Name:.

Permission to contact:

Your Address:

Occupation:

Emergency Contact/relationship:

Name/phone:

I have their permission to share

**Medical History & Contra-indications**:

**Postural Analysis**:

Spine – Kyphosis

Lordosis

Scoliosis

Shoulder - ^ left

^ right

None

**Pain Record:** Scale 0-10 (0 is no pain)

Date:

Pain:

To best monitor the effectiveness of treatment please complete the log below

Client Name:

DOB: Parental Consent: Yes No

**Important:** I work safely and professionally. I hold relevant Qualifications and Insurance. This form is therefore a legal requirement. While some questions may appear too personal or irrelevant for the treatment you have requested, I am required to do a full consultation for the safety of us both and for insurance purposes. On receipt of the information, I will discuss any contraindications with you securely via WhatsApp or phone so that prior to any appointment being booked, we will both have a clear understanding of what the appointment will look like, and any oils or creams will be made up ready. The form will be saved securely on OneDrive and printed documents will be locked away.

Please highlight

**Please answer YES, NO or give more information on page 3. This is how your treatment is tailored to meet your individual needs. Anything in the last 5 years, may require GP consent.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Skin Conditions:** |  | Normal/oily/dry/sensitive |  |
| Psoriasis  |  | Scars |  |
| Acne |  | Bruising  |  |
| Warts |  | Eczema |  |
| Moles |  | Weeping eczema |  |
| Recent surgery/Scar tissue |  | Sun burn |  |
| For me: Possible EO or carriers:  |  |
| **Nervous system:** |  | Diabetes |  |
| Headaches |  | Loss of sensation |  |
| Epilepsy |  | ME/CFS/fibro |  |
| For me: Possible EO or carriers:  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Muscular/skeletal system:** |  | Back problems  |  |
| Fractures/sprains/strains |  | Arthritis |  |
| Cuts and abrasions |  | Undiagnosed lumps |  |
| Neck problems  |  | other  |  |
| For me: Possible EO or carriers:  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Circulatory system:** |  | Haemophilia  |  |
| Blood Pressure problems |  | Pacemaker  |  |
| Hypotension |  | Thrombosis |  |
| Hypertension |  | Oedema |  |
| Varicose veins  |  | Phlebitis |  |
| Heart Disease  |  |  |  |
| For me: Possible EO or carriers:  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Endocrine system:** |  | Children |  |
| Menopause/HRT |  | Pregnant |  |
| PMT |  | Breastfeeding |  |
| Trying to conceive |  |  |  |
| For me: Possible EO or carriers:  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Digestive system:** |  | IBS |  |
| Constipation |  | IBD |  |
| Bloating |  | Celiac disease |  |
| For me: Possible EO or carriers:  |  |

**Treatment Objectives** (please see treatment plan or log)

What are the main reasons for wanting to book today? ie: pain, relax etc

|  |  |  |  |
| --- | --- | --- | --- |
| **Immune system:** |  | Fever |  |
| Allergies |  | Radiotherapy |  |
| Product allergy  |  | Chemotherapy |  |
| Medication |  | Other Cancer treatments |  |
| Contagious diseases |  | HIV |  |
| For me: Possible EO or carriers:  |  |

Sign Client: Date: Sign Therapist: Date

**MEDICATION AND CONTRAINDICATIONS**

Do you take any medication? Please just write the name, I will complete the rest.

|  |  |  |  |
| --- | --- | --- | --- |
| Name of medication | Purpose | Type | Contraindicated/why |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |

Sign Client: Date: Sign Therapist: Date

Any Other Relevant Information around your Medical History or changes since first session can be logged here

**Session 2 -** Changes since last treatment **Yes No**

**Details:**

**Treatment Objectives:**

Notes:

Sign Client: Date: Sign Therapist: Date

**Session 3 -** Changes since last treatment **Yes No**

**Details:**

**Treatment Objectives:**

Notes:

Sign Client: Date: Sign Therapist: Date

**Session 4** - Changes since last treatment **Yes No**

**Details:**

**Treatment Objectives:**

Notes:

Sign Client: Date: Sign Therapist: Date

**Session 5 -** Changes since last treatment **Yes No**

**Details:**

**Treatment Objectives:**

Notes:

Sign Client: Date: Sign Therapist: Date

**Any other comments**

Any Other Relevant Information contd

**Session 6 -** Changes since last treatment **Yes No**

**Details:**

**Treatment Objectives:**

Notes:

Sign Client: Date: Sign Therapist: Date

**Pain Record:** Scale 0-10 (0 is no pain)

|  |  |  |
| --- | --- | --- |
| Before treatment | Immediately after | X days after |
| After Session 1 |  |  |
| After Session 2 |  |  |
| After Session 3 |  |  |
| After Session 4 |  |  |
| After Session 5 |  |  |
| After Session 6 |  |  |