Client Name:

DOB: Parental Consent: Yes No

Precious' Holistic & Beauty Treatments

Client Record Form

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.

Your Address:

Occupation:

Emergency Contact/relationship:

Name/phone:

I have their permission to share

Surgery/GP Name:.

Permission to contact:

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

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

Medical History & Contra-indications:

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:			

Immune system:		Fever	
Allergies		Radiotherapy	
Product allergy		Chemotherapy	
Medication		Other Cancer treatments	
Contagious diseases		HIV	
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

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

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 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		

Any other comments