



In order to make your treatment as effective and safe as possible, please complete the form below prior to your treatment.

All information collated is **STRICTLY CONFIDENTIAL** and will be preserved as part of your client record.

Please ensure you complete the consultation form as thoroughly as you can, noting any surgery or illnesses you may have had in the last 2 years. Remember to include details of any medication you may be on for any conditions, allergies or illnesses which may be impacted by the treatment.

Personal Details	
Full Name	
Address	
Postcode	
Home or Mobile Number	
Email Address	
Date of Birth	
GP Details	
Accidents / Injuries / Operations (Past or Present)	
History of Medical Conditions – Past or Present (i.e Diabetes, Cancer, HIV, Asthma)	
How is your current state of health? Good/Poor etc.	
Do you have any allergies? i.e nuts Details	
Any other details your therapist should be aware of? i.e Pregnancy	

I have not withheld any information regarding my health and the information I have provided is true to the best of my knowledge. I understand - as my body adjusts to the treatment provided - I may develop some minor reactions to it. I have been informed of contra indications and whilst all due care will be taken by my therapist I am aware that my involvement in the treatment is of my own choice.

Treatment/s Received:

Client Signature:

Date:
