



Client Consultation Form

Client Name: _____ - DOB _____

Address: _____

Tel. No: Day _____ Eve _____

E-mail _____

Profession: _____

Date of Consultation: _____

PERSONAL DETAILS

Age group: Under 20 20-30 30-40 40-50 50-60 60+

Lifestyle: Active Sedentary

Last visit to the doctor: _____

GP Address: _____

No. Of children (if applicable): _____

Date of last period (if applicable): _____

CONTRAINDICATIONS (select if/where appropriate):

Never treat unless the injury has been diagnosed and treatment has been recommended by a medical practitioner.

Pregnancy

Cardio vascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)

Haemophilia

Any condition already being treated by a GP or another health professional, e.g.

Physiotherapist, Osteopath, Chiropractor, Coach

Medical oedema

Osteoporosis

Arthritis

Nervous/Psychotic conditions

Epilepsy

Recent operations

Diabetes

Asthma

Any dysfunction of the nervous system (e.g. Muscular sclerosis, Parkinson's disease, Motor neurone disease)

Bells Palsy

Trapped/Pinched nerve (e.g. sciatica)

Inflamed nerve

Cancer

Postural deformities

Spastic conditions

Kidney infections

Whiplash

Slipped disc

Undiagnosed pain

When taking prescribed medication

Acute rheumatism

CONTRAINDICATIONS THAT RESTRICT TREATMENT (select if/where appropriate):

Fever

Contagious or infectious diseases

Under the influence of recreational drugs or alcohol

Diarrhoea and vomiting

Skin diseases

Undiagnosed lumps and bumps

Localised swelling

Inflammation

Varicose veins

Pregnancy (abdomen)

Cuts

Bruises

Abrasions

Scar tissues (2 years for major operation and 6 months for a small scar)

Sunburn

Hormonal implants

Abdomen (first few days of menstruation depending how the client feels)

Haematoma

Hernia

Recent fractures (minimum 3 months)

Cervical spondylitis

Gastric ulcers

After a heavy meal

WRITTEN PERMISSION REQUIRED BY GP/SPECIALIST (which should be attached to the consultation form): Yes No

PERSONAL INFORMATION (select if/where appropriate):

Muscular/Skeletal problems: Back Aches/Pain Stiff joints Headaches
Digestive problems: Constipation Bloating Liver/Gall bladder Stomach
Circulation: Heart Blood pressure Fluid retention Tired legs Varicose veins
Cellulite Kidney problems Cold hands and feet
Gynaecological: Irregular periods P.M.T Menopause H.R.T Pill Coil
Other: _____
Nervous system: Migraine Tension Stress Depression
Immune system: Prone to infections Sore throats Colds Chest Sinuses
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:

How many portions of each of these items does your diet contain per day?

Fresh fruit : Fresh vegetables : Protein: source? meat/fish
Dairy produce: Sweet things : Added salt: Added sugar:

How many units of these drinks do you consume per day?

Tea: Coffee: Fruit juice: Water: Soft drinks: Others:

Do you suffer from food allergies? Yes No Bingeing? Yes No

Overeating? Yes No

Do you smoke? No Yes How many per day?

Do you drink alcohol? No Yes How many units per day?

Do you exercise? None Occasional Irregular Regular Type:

What is your skin type? Dry Oil Combination Sensitive Dehydrated

Do you suffer/have you suffered from: Dermatitis Acne Eczema Psoriasis

Allergies Hay Fever Asthma Skin cancer

Stress level: 1–10 (10 being the highest)

At work At home

PHYSICAL EXAMINATION – ALIGNMENT

Head:

Shoulders:

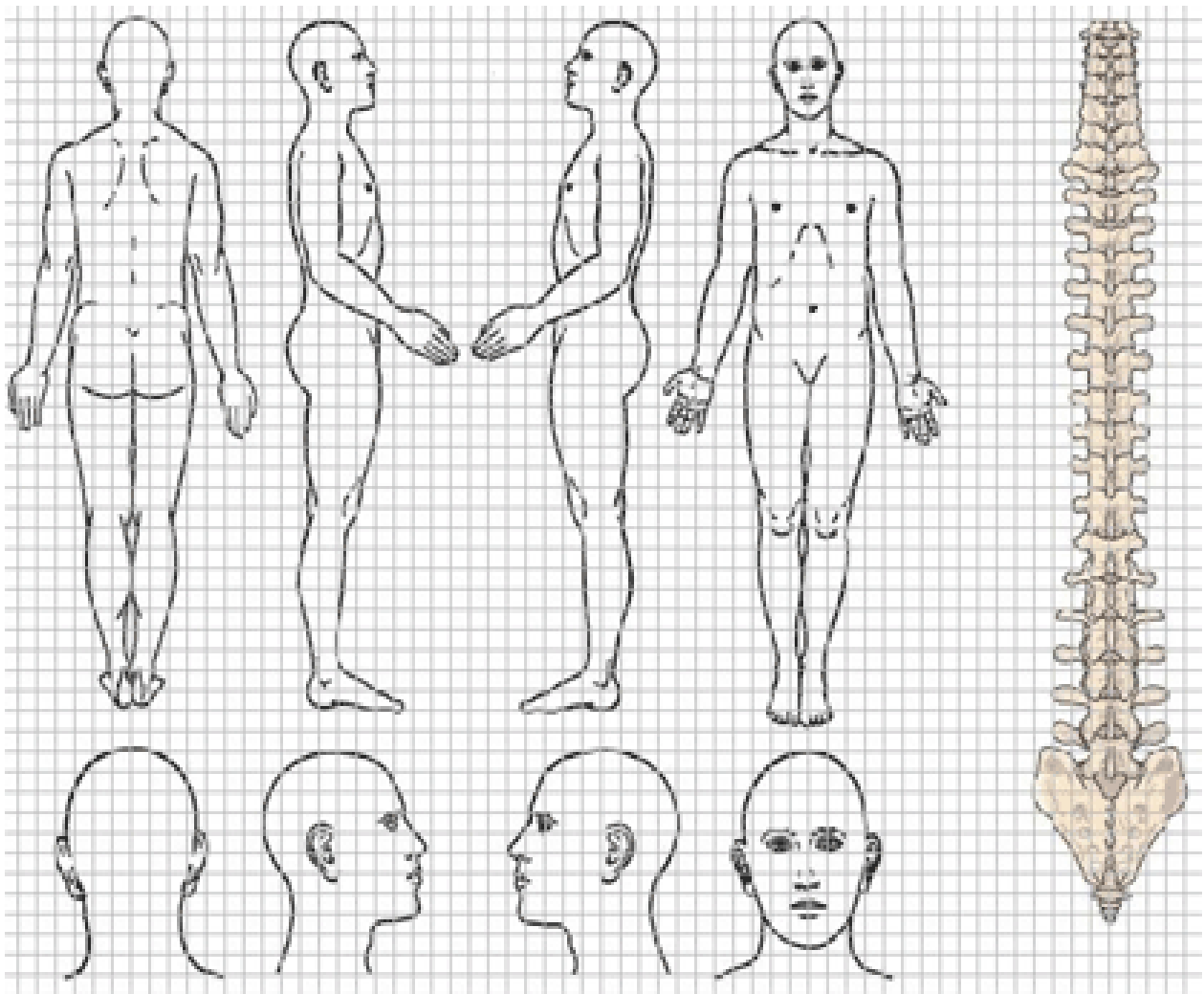
Back:

Pelvis:

Legs:

Feet:

Body alignment/posture:



Client Information

Please read carefully and only sign if you are in full agreement with its contents

I _____ confirm that I have understood the treatment that I am to receive and confirm that I am willing to proceed without confirmation from my own GP or Consultant.

Or

I _____ confirm that I have understood the treatment and given my medical history I would prefer to consult with my GP or Consultant prior to receiving the treatment.

It is your responsibility and not that of the therapist to consult your GP or Consultant.

I hereby indemnify the therapist against any adverse reaction sustained as a result of the treatment

Client Signature.....

Date.....

Therapist Signature.....

Date.....