

Client Consultation Form



Personal Details

Surname	First name (s)
Address	
	Postcode
Telephone No	Mobile No
Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male
Profession / Occupation	

Lifestyle

Do you smoke?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, number per day
Do you exercise regularly?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you drink?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, approx units per week
Stress levels?	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	
Do you sleep well/take time to relax?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you drink plenty of water?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you eat a balanced diet?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Condition of general health?	<input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Poor	

Medical History

Are you currently taking any type of medication?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, please provide full details	
Are you currently under the care of (or waiting to see) a medical practitioner?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, please provide full details	

Please select yes or no from the following list of possible contra-indications to treatment. This list is not exhaustive and it is therefore imperative that you state on this form any other condition that you have (diagnosed or otherwise) before any treatment.

You are or may be pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Conditions affecting the heart/circulation/blood disorders?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Contagious skin diseases or signs of infection?	<input type="checkbox"/> No <input type="checkbox"/> Yes
High or low blood pressure?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have cancer or any other life threatening diseases?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Undiagnosed lumps, bumps, rashes or swelling?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Recent haemorrhaging?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Thrombosis or embolism?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diabetes?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Epilepsy?	<input type="checkbox"/> No <input type="checkbox"/> Yes
You are intoxicated?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Infectious diseases or viruses?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Medical History (cont)

You have a fever/illness/migraine attack	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Surgical procedures within the last 6 months? (1 year if major)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Nervous system disorder?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Any allergies?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Metal plates, pins or pacemaker?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Severe eczema or psoriasis?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Severe asthma or difficulties breathing when lying down?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Highly sensitive, vascular or red skin?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cuts or infections?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Severe arthritis or joint or bone problems?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Please provide any further information or conditions in the box below.

GP's Name

Surgery address

Telephone No

How did you hear about Willow Spa?

Disclaimer

I confirm that the above information is true to the best of my knowledge and belief. I agree to inform my therapist of any changes to the above information that may be relevant prior to any treatment. I have been fully informed about the expected results from the treatment and agree to follow any after-care advice provided by my therapist. I hereby give my consent to proceed with treatment (s).

Client Signature

Date

Therapists Signature

Date

In accordance with the Data Protection Act, client records are confidential and are stored in a secure place. Client's personal details will not be disclosed or discussed with any third party without the client's express permission.

Therapists notes

GP Permission required? No Yes If yes, attach copy of letter

Skin patch test required? No Yes

Patch test product and area tested

Date of patch test Patch test result

Notes