

Consultation Form

Client's Name \_\_\_\_\_

E-mail \_\_\_\_\_ Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_

Where did you hear about me? \_\_\_\_\_

Would you like to be kept informed of special offers? Yes/No

Reason for visit e.g. stress, backache \_\_\_\_\_

Medication (incl birth pill/HRT/Vitamins) \_\_\_\_\_

Any recent Accidents, Illnesses, Injuries, Operations? \_\_\_\_\_

Do you suffer from high/low blood pressure, phlebitis/thrombosis, varicose veins, epilepsy, arthritis, rheumatism, gout, diabetes, haemophilia, sinusitis, anxiety/depression, back complaint, migraine, recurrent infections, skin condition (including sensitive skin) or any other complaint of the muscular, skeletal, endocrine (hormone) or nervous system?

Are you currently under the care of a doctor or other professional? \_\_\_\_\_

Are you allergic to nuts? \_\_\_\_\_

Do you intend to use a sunbed/be in bright sunlight within the next 48 hours? \_\_\_\_\_

Have you ever had an Aromatherapy/Reflexology/Massage treatment before? \_\_\_\_\_

What level of pressure do you like-light, medium or firm? \_\_\_\_\_

Would you describe your current levels of stress as low, medium or high? \_\_\_\_\_

Do you have a healthy diet? \_\_\_\_\_

Do you drink water? \_\_\_\_\_

Do you take regular exercise? \_\_\_\_\_

Do you sleep well? \_\_\_\_\_

General state of health: \_\_\_\_\_

I have read the above and confirm the answers, whether completed by me or not are accurate.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Therapist

\_\_\_\_\_  
Date