Client Consultation Form – *Complimentary Therapy*

(includes aromatherapy, holistic massage, Reiki, meditation, counselling, hot stones and Indian head massage)

Please use block capitals

Date: _____ Email: _____

Client Name: _____ Profession: _____

Address: _____ Tel. No: _____

_____ _____

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 REQUIRING MEDICAL PERMISSION – in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment. ***(select if/where appropriate):***

Pregnancy (use only mandarin) ☐
Cardiovascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions) ☐
Haemophilia ☐
Any condition already being treated by a GP or another complementary practitioner ☐
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 ☐
Muscular Spasms ☐
Kidney infections ☐
Hormonal implants ☐
Undiagnosed pain ☐
When taking prescribed medication ☐
Acute rheumatism ☐

CONTRAINDICTIONS THAT RESTRICT TREATMENT ***(select if/where appropriate)*****:**

Fever ☐
Contagious or infectious diseases ☐
Under the influence of alcohol or recreational drugs ☐
Diarrhoea and vomiting ☐
Skin diseases ☐
Undiagnosed lumps and bumps ☐
Localised swelling ☐
Inflammation ☐
Varicose veins ☐
Pregnancy (abdomen) ☐
Breast feeding ☐
Cuts ☐
Bruises ☐
Abrasions ☐
Abdomen (first few days of menstruation depending how the client feels) ☐
Haematoma ☐
Recent fractures (minimum 3 months) ☐
Cervical spondylitis ☐
Whiplash ☐
Slipped disc ☐
Gastric ulcers ☐
Hernia ☐
After a heavy meal ☐
Hypersensitive skin ☐
Sunburn ☐
Scar tissues (2 years for major operation and 6 months for a small scar) ☐

♦ **N.B. All known allergies should be checked**
Client contraindications should be checked against the safety data for each oil prior to treatment

WRITTEN PERMISSION REQUIRED BY:
GP/Specialist ☐ Informed consent ☐
Either of which should be attached to the consultation form.

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☐ Anxiety☐ Other☐
Immune system: Prone to infections☐ Sore throats☐ Colds☐ Chest☐ Sinuses☐
Regular antibiotic/medication taken:
Herbal remedies taken:
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☐
How many portions of each of these items does your diet contain per day?
Fresh fruit: Fresh vegetables: Protein: source?
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☐ Types
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

Reason for Treatment

Date: ……..

Therapist Signature: ……

Client Signature: ……