CONFIDENTIAL

CLIENT CONSULTATION FORM

CONSULTATION FORM

SECTION A - *Complete this section if you are a new customer, or if you have NOT filled out this section on another consultation form previously.*

Name:

Mobile:

Landline:

Email:

Occupation: *(optional)*

DOB: *(optional)* Age: *(optional)*

Doctor/GP: *(optional)*

GP Address: *(optional)*

Address:

Height: *(optional)* Weight: *(optional)*

Do you Smoke? Y ☐ N ☐ Daily Quantity:

GP Tel: *(optional)*

SECTION B - *Please complete this section*

What is the reason for your treatment?

Medical Background *(Tick all that apply):*

Muscular System - including injuries, ache or pain in muscles and joints *(briefly explain):* Yes ☐ No ☐

Skeletal System - including injuries, fractures, arthritis *(briefly explain):* Yes ☐ No ☐

Circulatory System - including heart, angina, thrombosis, varicose veins, fluid retention, family history *(briefly explain):* Yes ☐ No ☐

Blood Pressure - including hypertension, hypotension, medication, stable, unstable *(briefly explain):* Yes ☐ No ☐

Lymphatic System - including swelling in lymph glands, tonsils, adenoids, frequent infection *(briefly explain):* Yes ☐ No ☐

Respiratory System - including bronchitis, asthma, sinusitis, ear infections, cough *(briefly explain):* Yes ☐ No ☐

Nervous System - including headaches, migraine, tension, stress, anxiety depression *(briefly explain):* Yes ☐ No ☐

Cancer - including diagnosis, date, treatment, medication, prognosis, remission, family history *(briefly explain):* Yes ☐ No ☐

Allergic Reactions - including triggers e.g. medication, supplements, food, additives, beeswax, products *(briefly explain):* Yes ☐ No ☐

Diabetes - including stable, unstable, diet or medically controlled, family history *(briefly explain):* Yes ☐ No ☐

Operations - including dates, locations, scarring *(briefly explain):* Yes ☐ No ☐

Medical Background Continued *(Tick all that apply):*

Medications - including prescribed, supplements, over the counter *(briefly explain):*

Yes ☐ No ☐

Skin issues - including Dermatitis, Acne, Eczema, Psoriasis, Skin Allergies, Skin Infections to outer ear/face/scalp. *(briefly explain):*

Yes ☐ No ☐

Do you drink alcohol? *(If yes, what is your weekly alcohol consumption):*

Yes ☐ No ☐

Do you exercise? *(If yes, list types and frequency of excercise)*

Yes ☐ No ☐

Do you get 6 or more hours of sleep daily? *(describe pattern, duration, ease of getting to sleep, wake feeling refreshed, disturbed)*

Yes ☐ No ☐

Are you happy with your diet? *(describe i.e., regular, reduced, gluten free, vegan, vegetarian, diabetic, dairy free, sugar free, etc.):*

Yes ☐ No ☐

Do you drink enough fluids? *(describe your daily fluid intake: Water, Tea, Coffee, Fruit Juice, Other, and quantities of same):*

Yes ☐ No ☐

Do you get stressed regularly? *(Rate your stress levels on a scale from 1 – 10 (10 being the highest) and describe frequency:*

Yes ☐ No ☐

Additional Information:

SECTION C - *Complete this section if you are a new customer, or if you have NOT filled out this section on another consultation form previously.*

Please provide us with two contacts in case of an emergency. Thank you.

EMERGENCY CONTACT 1		EMERGENCY CONTACT 2	
Name:		Name:	
Mobile:		Mobile:	
Town:		Town:	
Relationship to you:		Relationship to you:	

SECTION D - *Please complete this section*

By signing this document, I attest to the truthfulness and completeness of the information provided in this form /consultation, to my therapist regarding my health. I hereby declare that I have not withheld any information that may affect the outcome of the treatment. The treatment has been fully explained and I have been made aware of any possible reactions which could occur. I hereby indemnify therapist, **Denise Coleman** against any adverse reactions that I may feel are sustained as a result of the treatment.

I give permission to this therapist to hold my records: **A)** to best deliver their services ☐ **B)** to confirm appointments ☐ *(Please tick both boxes)*

I acknowledge that typing my name below constitutes my electronic signature and signifies my consent to the terms and conditions outlined above.

Client Signature: **Date**:

Please complete the form and either email it to info@denisecoleman.com or bring a printed copy to your initial appointment. Failure to do so may result in the inability to proceed with treatment.