**Confidential Consultation Form**

**Personal Information**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mob Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Post Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_

GP &Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact & Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Therapist: Toni Creevy**☐



 **Lifestyle Information**

Stress Levels: 1 2 3 4 5 6 7 8 9 10

Define sleep/ Hrs\_\_\_\_\_\_\_\_\_\_\_ ☐Snore ☐Grind Teeth

☐Water \_\_\_\_\_ ☐Tea\_\_\_\_\_\_\_ ☐Coffee\_\_\_\_\_\_ ☐Alcohol\_\_\_\_

☐Smoke\_\_\_\_\_\_\_ ☐Drugs\_\_\_\_\_\_\_\_\_ ☐Exercise \_\_\_\_\_\_\_\_\_\_\_

☐Sit for long hrs \_\_\_\_\_\_\_\_\_\_\_\_ ☐Computer ☐Driver

☐Diet \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information**

Are you taking any medications? ☐Yes ☐No

Please list name & use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate any of the following that apply to you:

Tension☐ Stiffness☐ Back Pain☐ Shoulder Pain☐ Pain☐ \_\_\_\_\_\_\_\_ Spinal Problems☐ Arthritis/Rheumatism☐ Recent Fracture☐ Recent Sprain/Strain☐ Osteoporosis☐

Major illnesses☐ Operations☐ Surgery☐

Knee Replacement☐ Hip Replacement☐ Cosmetic Surgery☐ Breast Implants☐ Denture/Bridge☐ Surgery in last 6 Mths☐

Blood Clot☐ Breathing Difficulty/Asthma☐ HeartAtt/Stroke☐ High/Low Blood Pressure. ☐ Varicose vein☐

Diabetes☐ Kidney Dysfunction☐ Bowel/Stomach☐ IBS☐ Constipation☐ Colitis☐ Crohns☐ Water retention☐ Lymphedema☐

Epilepsy/fainting/dizziness☐ Headaches/Migraines☐

Jaw Pain☐ Sinus Problems☐ Hayfever ☐ Hearing Aid☐

Fatigue☐ Fibromyalgia/ME/MS/CFS☐ Thyroid☐ Cancer☐ Prostrate issue☐ Anxiety/Depression☐

Skin Problems☐ Skin Allergies☐ Rashes☐

Pregnant☐Mths \_\_\_\_\_Complicated Birth☐ Menstrual issue☐

**Further Information**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment Information**

Do you have Emergency Response Allergies-nuts/oils? ☐Yes ☐No

Type of Treatment: ☐Bowen Therapy ☐MLD

☐ Relaxation Massage ☐ Deep Tissue Massage ☐Head/Scalp ☐Dermalux LED ☐Healing

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐Yes ☐ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What pressure do you prefer? ☐Light ☐Medium ☐Deep

What is your goal for this treatment session? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor Diagnosis/Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main Presenting Issues\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*By signing below, you agree to the following.*

*I have completed this form to the best of my ability/ knowledge & agree to inform my therapist if any of the above information changes at any time. I will not hold the therapist responsible for any errors or omissions that have been made. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques. I give my permission for myself/ my child to have this therapy and understand that all information discussed in this treatment is confidential. This therapy is designed to be a health aid & is not to substitute your GP/medical treatment, but to work alongside.*

***Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_***