**Logo

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**TO BE COMPLETED AND RETURNED PRIOR TO INITIAL CONSULTATION: STRICTLY CONFIDENTIAL**

The following information is required for your child’s safety, and to benefit their health and welfare. If there is anything you feel uncomfortable answering or you do not know the answer to, please do not worry. The details you do provide will, of course, be treated with the strictest confidence.

|  |  |
| --- | --- |
| **First Name:** |  |
| **Last Name:** |  |
| **Date of Birth:** |  |
| **Gender:** | **Male [ ] Female [ ] Other [ ] Prefer not to say [ ]** |
| **Address:** |  |
| **Email:** |  |
| **Telephone Number:** |  |
| **Mobile Number:** |  |
| **Does the child live with you?** |  |

|  |  |
| --- | --- |
| **Doctors Address:** |  |
| **Doctors Telephone Number:** |  |
| **Other medical specialists:** |  |

**Does your child suffer, or have they ever suffered, from any of the following?** Please do not worry about providing details about any ‘YES’ answers, we will discuss them during your initial consultation.

Diabetes Y/N Varicose Veins Y/N

Kidney Problems Y/N Deep Vein Thrombosis Y/N

Epilepsy Y/N Heart Disease Y/N

Photosensitivity Y/N High or Low Blood pressure Y/N

Surgery or injury Y/N Cancer Y/N

Sensitive Skin Y/N Stroke Y/N

Allergic Skin Rashes Y/N Asthma Y/N

Allergies Y/N Migraines Y/N

**Does your child have any DIAGNOSED mental health conditions?**

General Anxiety Disorder Y/N Schizophrenia Y/N

Panic Attacks       Y/N   Borderline Personality Disorder Y/N

Stress       Y/N Dementia Y/N

Depression Y/N ADHD Y/N

Postnatal Depression Y/N OCD Y/N

Bipolar Y/N PTSD Y/N

Phobias Y/N Eating Disorders Y/N

Other Y/N

**Is there anything else it would be useful for your therapist to know?**

‘I can’t put my finger on it but I’m worried about her/him’ is a legitimate and welcome answer.

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**Is your child currently taking any prescribed or self-prescribed drugs or remedies, including illicit substances?** Please be as honest as you feel you can, it will help us to help you. ALL information is received and stored with the strictest confidentiality protocols.

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**Have they received their COVID vaccination/s if applicable?** Y/N   
**If so, please provide dates if possible**

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Do they exercise? Please provide an outline of what exercise they do and how often**

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**What are their hobbies?..................................................................................................................**

**Are they currently receiving, or have they previously received any other therapy?**

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**Finally, please let us know if they have a phobia of dogs Y/N**

Our resident recovery pup, Leo, sometimes makes an appearance - however if it's not their thing, we will make sure he doesn't.

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**Personal Consent**

By signing this form, I understand that I am giving consent for my child to receive treatment provided by Lighthouse holistic Therapy. I am fully aware that the services I wish my child to receive are those of a holistic nature and do not serve as a substitute for professional medical advice, examination, diagnosis, or treatment.

I fully understand this treatment may take several sessions before they notice any benefit. This will depend on their lifestyle, ongoing medication, and general health.

I understand that if I have been untruthful with any details or have failed to give enough relevant information the outcome of any therapy or treatment could be adversely affected and their health and well-being may be put at risk.

I agree to inform Lighthouse Holistic of any changes in my child’s health or medical conditions. I understand that there shall be no liability on the therapist's part should I forget to do so.

By signing this release, I hereby waive and release my therapist from all liability past, present, and future relating to my child’s treatments.

I understand the therapist/practitioner/trainer does not claim to cure or to diagnose any medical condition in the same way as a doctor. Their opinion is that of a holistic, complementary, and alternative therapist and their professional opinions, advice, examinations, and recommendations do not constitute the medical advice of a doctor. If necessary, the therapist will provide a referral to a medical professional for further diagnosis if required. I am under no obligation to accept or act upon the referral or the advice provided.

I confirm that I have given my child’s personal details for use by Lighthouse Holistic Therapy in connection with the therapy or treatment they receive, and consent to the storage of these details for at least ten years. I confirm that you may retain this information so that you can contact me again in the future.

**Are you happy for us to periodically email you with special offers, news, views, and useful information that we think you may enjoy?** Y/N

Signature: ………………………………………………………………………………. (Parent if child is under 16)

Date: ……………………………………………………………………………….

**Thank you!**

Please return your completed form via email to timeforme@lighthouseholistictherapy.com and [info@lighthouseholistictherapy.com](mailto:info@lighthouseholistictherapy.com) prior to your initial consultation.