

CLIENT INFORMATION SHEET
ALL QUESTIONS ON THIS FORM ARE STRICTLY PRIVATE AND CONFIDENTIAL

Before completing this form please read below;

I am UNABLE to give you a Massage if you have any of the following;

If you are currently; Under the Influence of Drugs or Alcohol or have had an operation (anaesthetic) in the last 3-6 months. If you are currently suffering from; Fever, sore throat or cold, Active contagious infection, any viral infection, active Impetigo, Tinea Corpis or Pedis, Acute Bronchitis, Pleurisy, Pneumonia, Tuberculosis, Nephritis, Pyelonephritis, Migraine, Pre-Eclampsia, Hematoma, Acute High Blood Pressure, Active Hodgkin's, Shingles, Septicaemia, Hepatitis, have hormonal implants.
If you ever had; Thrombus, Thrombosis or Coronary Thrombosis,

I am UNABLE to give you Reflexology if you have any of the following;

An organ transplant, aneurysm, flebitis, arthritis in your feet,
If you are currently suffering from; Fever, sore throat or cold, Active contagious infection, any viral infection, Active Impetigo, Tinea Pedis,

Please note; There are instances where I cannot give you a massage but I can give you reflexology. If I need to amend your treatment I will inform you.

If you have cancer you may wish to consult with your oncologist before making an appointment with me.

PERSONAL DETAILS

Full Name

Date of Birth

Address

Age

Sex

Contact Tel

Marital Status

Email

Occupation

Name and TelNo of GP/Gynaecologist/Midwife

Name and number of person to contact in case of emergencies;

What are your reasons for coming to see me?

Have you received any holistic therapies in the past, if so what?

MEDICAL INFORMATION

What is your current state of your general health?

Are you currently seeing your Dr or any other specialist for treatment, if so please explain?

Do you have any allergies ie; Nut, washing powder etc

Any urinary tract, bladder infections within the last year?

Are you a heart patient?

Please tell me if you have any other serious medical conditions I need to know about ie; Cancer, Intravenous drug user;

What condition is your skin in	Dry	Oily	Combination	Sunburnt
Do you have any of the following;				
Broken Bones		Eczema		Anaemia
Athlete's Foot		Psoriasis		High/low Blood Pressure
Verruca's		Osteoarthritis		Diabetes
Tendonitis		Acute Rheumatism		Haemophilia
Muscle Injuries		Kyphosis		Poor circulation
Recent Scar Tissue		Lordosis		Leukemia
Sinus problems		Scoliosis		HIV
Muscle Cramps		Back Pain		AIDS
Headaches		Gout		Chronic Fatigue Syndrome
Varicose Veins		Slipped Disc		Asthma
Poor Circulation		Torticollis		Breathing Difficulties
Arteriosclerosis		Ankylosing Spondylitis		Crohn's
Phlebitis		Migraines		Ulcers
IBS		Spasticity		Trapped Nerves
Constipation		Angina		Bells Palsy
Indigestion		Medical Oedema		Epilepsy
Heartburn		Kidney Stones		Nervous/Psychotic conditions

WOMEN ONLY

Are you pregnant?	If so how many weeks?	What is your due date?		
Have you recently had a baby?				
If so how was the delivery ie; C-section, epidural?				
Number of pregnancies	Number of miscarriages	Number of terminations		
Are you currently receiving fertility treatment, if so what sort?				
How long is you menstrual cycle?				
Are you pregnant or breastfeeding?			Yes	No
Have you had a D&C, hysterectomy or Caesarean?			Yes	No
Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around time of period?			Yes	No
Do you suffer from PMS?			Yes	No
Are you Menopausal?			Yes	No
Are you receiving HRT?			Yes	No

LIFESTYLE

Exercise	Sedentary (No exercise)					
	Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
	What sort of exercise do you do?					
Diet	Are you dieting?			Yes	No	
	No. of meals you eat in an average day?					
	Do you drink Caffeine?	None	No. of cups/cans per day?	Coffee	Tea	Cola
	How much water do you drink per day?					

	Do you drink alcohol?	Yes	No
	If yes, what kind?		
	How many units per week?		
Tobacco	Do you use tobacco?	Yes	No
	Cigarettes – pks./day		Cigars – No./day
	Chew – No./day		
	Pipe – No./day		
	No. of years		Or year quit
Work	Is your work sedentary?	Yes	No
	Do you work in an air conditioned environment?	Yes	No
	Do you commute to work if so how?		
Stress	Rate your stress on a scale of 1 (being lowest) – 10		
	What areas of your life are causing you stress?		

What do you do to relax?

What are your interests/Hobbies?

How many hours sleep do you get per night?

DISCLAIMER

I agree that all the above information is correct to the best of my knowledge and I wish to go ahead with this treatment I have not withheld any information and if any of this information changes I agree to inform you immediately.

Signed by Client

Date

Signed by Parent/Guardian

Date

Signed by Therapist

Date

