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

Before completing this form please read below;

I am UNABLE to treat 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 Tel No 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, (including listing prescribed medication and any side effects experienced)?

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, shampoo, essential oils, face products 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.

Do you have any of the following;

Heartburn	Kidney Stones	Broken Bone	Eczema
Anaemia	Athlete's Foot	Psoriasis	High/Low Blood
Pressure	Verucca's	Osteoarthritis	Diabetes Tendonitis
Acute Rheumatism	Haemophilia	Leukaemia	Muscle Injuries
Poor circulation	Kyphosis/Lordosis/Scoliosis	Gout	Recent Scar tissue
Back Pain	Muscle Cramps	CFS	Varicose Veins
Slipped Disc	Asthma/Sinusitis	Arteriosclerosis	Crohn's
Ankylosing Spondylitis	Breathing difficulties	Phlebitis	Migraines/Headaches
IBS	Spasticity	Ulcers	Constipation
Angina	Trapped Nerves	Indigestion	Medical Oedema
Bell's Palsy	Heartburn	Epilepsy	Haemorrhoids
Spine/Back issues	Cold feet/Hands	Osteoporosis	Bruxism
Cold sores	Face lift (6mths)	Fillers	Skin cancer
Rosacea	Frozen Shoulder	Active Acne	Sleep issues
HIV/AIDS	Thyroid Issues	Nervous/Psychotic conditions	

What condition is your skin in: Dry Combination Oily Sunburnt

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 How much exercise do you do in a week? Non Light Occasional sport Regular

What sort of exercise do you do?

DIET Are you on a diet, if so what sort?

No of meals you eat in a day

Do you drink Caffeine (tea, coffee, Cola) and if so how much a day?

How much water do you dink per day?

Do you drink Alcohol, if so what sort and how much per week?

Do you smoke/vape/use tobacco including nicotine patches, if so how often and for how many years?

WORK Is you work sedentary?

Do you work in an air-conditioned environment?

Do you commute to work and if so how?

STRESS Rate your stress on a level of 1-10 (1 being lowest)

What areas of your life are causing you stress

What do you do to relax interests/hobbies?

How many hours sleep do you get a 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