WOOD THERAPY CONSULTATION FORM

Name:_____ Date of Birth:____/_____/_____

Address:_____

City:_____ County:_____ Postcode:_____

Phone #: _____ Email:_____

Occupation:_____ Work Phone#_____

Emergency Contact:_____ #: _____

Wood Therapy intensifies the breakdown of fat and fibrous cellulite, so that it can be eliminated naturally with other toxins. This technique employs repetitive movements using different wooden instruments to manipulate targeted areas of muscle, fat and cellulite, stimulating the lymphatic drainage system to remove unnecessary water, fat and toxins from the body. A series of 10-15 treatments is necessary to achieve the desired results.

Wood Therapy Treatment Plan

The technique employs a series of repetitive movements using more than a dozen different wooden implements. These implements manipulate targeted areas of muscle, fat and cellulite, stimulating the lymphatic drainage system to rid the body of stored toxins. This jump starts metabolism to burn fat. The manipulation serves to release toxins and break down stubborn pockets of cellulite, thereby shrinking disproportionate bulges and smoothing orange-peel dimples.

MEDICAL HISTORY

Are you currently under the care of a physician? ☐ Yes ☐ No

If Yes, please explain:_____

_____

Do you have any of the following medical conditions? (Please check all that apply):

- ☐ Fever
- ☐ Recent Operation
- ☐ Acute Injury
- ☐ Neuritis
- ☐ Skin Disease
- ☐ Varicose Veins
- ☐ Undiagnosed Lumps or Bumps
- ☐ Trapped or Pinched Nerves
- ☐ Contagious Disease (including any cold or flu, no matter how mild it may seem)
- ☐ Bruise easily
- ☐ Open Cuts or Abrasions
- ☐ Sunburn
- ☐ Undiagnosed Pain
- ☐ Inflammation
- ☐ Arthritis
- ☐ Oedema
- ☐ Gynecological Infection
- ☐ Cardio-Vascular Conditions (Thrombosis, Phlebitis, Hypertension, Heart Conditions)
- ☐ Psoriasis or Eczema
- ☐ Uncontrolled High Blood Pressure
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Nervous or Psychotic Condition
- ☐ Heart Problems, Angina or Pacemaker
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Bells Palsy

Do you have any other Health or Medical Conditions not listed above? ☐ Yes ☐ No

If Yes, Please list:_____

_____

Do you have any Allergies? ☐ Yes ☐ No If Yes, Please list all Allergies:_____

_____

Are you currently taking any Medications? ☐ Yes ☐ No If Yes, Please list all Medications including Oral Medication Topical Creams, Vitamins, and Supplements:_____

_____

Are you Pregnant, Breastfeeding, or Nursing? (Female Clients) ☐ Yes ☐ No