Consultation Form

Full name:

Treatment:

Date:

Do you suffer from or have any of the following?

Condition	Yes	No	Comments
Diabetes			
High blood pressure			
Low blood pressure			
Heart conditions			
Blood conditions			
Cancer			
Osteoporosis			
Undiagnosed pain			
Asthma			
Trapped/pinched nerve			
Epilepsy			
Nervous system dysfunction			
Whiplash			
Acute rheumatism			
Arthritis			
Recent operations			
Any form of infection, disease or fever			
Diarrhoea or vomiting			
Under the influence of recreational drugs or alcohol			
For women - are you in the first 3 months of pregnancy			

Consultation Form

Have you had any major illnesses, accidents or operations? Please give details below

Are you on any prescribed medication? Please give details below

Any other diagnosed condition being treated by a GP or other complementary practitioner? Please give details below

Are you receiving any other form of complementary therapy? Please give details below

Anything else not mentioned? Please give details below

Disclaimer

For my records, I need to confirm that you have read, understood and answered all of the previous questions. If there is anything that you do not understand, please ask me. Otherwise please read the following and sign below.

To the best of my knowledge, the information I have given is true, and I have not withheld any information concerning my health. I will keep the therapist updated on my health should there be any changes to answers given. I understand that the therapist does not diagnose illness, disease or any other physical or mental condition. I understand that this treatment is not a substitute for medical examination, diagnosis or treatment. While i recognise that all due care will be taken by the therapist, I am aware that my participation in the treatment is voluntary.

Please sign here:

Client: Date: