Client Consultation Form

The following information is required for your safety and to benefit your health. There are certain conditions, which may require special care. Please fill in or tick the box as appropriate. The information given will be treated in the strictest of confidence.

Personal Details:

Title: ..... Name: .....
Address:.....
.....
..... Postcode: .....
No. of Children: ..... Date of Birth: .....
Occupation: ..... Phone Number: .....
Email: .....
GP Name and Address:
.....
.....

Contraindications requiring medical permission:

In circumstances where medical permission cannot be obtained, informed consent in writing must be given prior to treatment by signing below.

Slipped disc ☐ Asthma ☐ Medical oedema ☐ Epilepsy ☐ Bell's Palsy ☐ Cancer ☐
Haemophilia ☐ Arthritis ☐ Kidney infections ☐ Whiplash ☐ Inflamed nerve ☐
Osteoporosis ☐ Diabetes ☐ Acute rheumatism ☐ Pregnancy ☐ Spastic condition ☐
Postural deformities ☐ Nervous/Psychotic Conditions ☐ Trapped/Pinched nerve (e.g. sciatica) ☐
Cardiovascular conditions ☐ (Muscular Sclerosis, Parkinson's disease, Motor Neurone Disease) ☐
Undiagnosed pain ☐ .....
Recent operations ☐ .....
Other condition being treated by GP or another complementary therapist:
.....
Prescribed medication:
.....

I confirm that I am happy to receive treatment without the therapist obtaining medical permission.

Client Signature: ..... Date: .....

Localised Contraindications:

Localised swelling ☐ Inflammation ☐ Sunburn ☐ Varicose veins ☐ Hormonal implants ☐
Cervical spondylitis ☐ Haematoma ☐ Hernia ☐ Gastric ulcers ☐ Cuts/Bruises ☐
Recent fractures (minimum 3 months) ☐ Undiagnosed lump/bumps ☐
Skin diseases (Eczema, Acne, Dermatitis, Psoriasis, other) ☐.....
Scar tissues (2 years for major and 6 months for a small scar) ☐ .....

Other details:

Muscular/Skeletal problems: Back ☐ ..... Stiff joints ☐ .....

Digestive problems: Constipation ☐ Bloating ☐ Stomach ☐ Liver/Gall bladder ☐

Circulation: Cold hands and feet ☐ Cellulite ☐ Tired legs ☐ Kidney problems ☐

Nervous system: Headaches ☐ Migraine ☐ Tension ☐ Stress ☐ Depression ☐

Immune system: Sore throat ☐ Sinuses ☐ Colds ☐ Chest ☐ Prone to infection ☐

Gynaecological: Menopause ☐ H.R.T. ☐ P.M.T. ☐ Pills ☐ Irregular periods ☐

Coil ☐ Other ☐ ..... Date of last period: .....

Aids or S.T.D. .....

Please detail any allergies that you may have .....

General state of health:

Stress levels: home: High ☐ Medium ☐ Low ☐ work: High ☐ Medium ☐ Low ☐

Sleep pattern: Good ☐ Average ☐ Poor ☐ Ability to relax: Good ☐ Average ☐ Poor ☐

Working at a computer: No ☐ Yes ☐ (hours daily/weekly) .....

Hobbies/relaxation activities: .....

Have you had a massage before? No ☐ Yes ☐ (recently?) .....

Reason for seeking treatment: .....

Client declaration:

I declare that the information I have given is correct and that as far as I am aware, I can undertake treatment without any adverse effects. I do not suffer any contagious diseases (diarrhoea, vomiting, etc.), which could spread to other clients coming to the clinic and I am not under the influence of recreational drugs or alcohol.

In undergoing this treatment, I understand that I am transacting with Quentin Corporate Services Limited and that, all treatments, actions, services, goods or any other provisions are supplied by them. I have been fully informed about the treatment and any contraindications and I am willing to proceed. I understand that any complementary therapy treatment does not substitute any medical treatment. I agree that my data can be securely stored by Quentin Corporate Services Limited, who will not share data with third parties without prior consent.

Please find attached to this form, our COVID 19 Risk Assessment. If there is no form attached, please refer to the printed copy in the clinic or feel free to ask for a copy.

Client Signature: ..... Date: .....