



Confidential Client Record Form

PERSONAL DETAILS		DATE
NAME:		Date of Birth:
Address:		Age:
		Marital Status:
		Sex:
Postcode:		Height:
PHONE (HOME):		Weight:
PHONE (MOBILE):		Profession:
EMAIL:	@	No & age of Children:
GP's name & address:		Where did you here about me?

Conditions which may require a GP referral are capitalised below.

Completed record forms will be assessed before treatment. The Therapist reserves the right not to treat the client.

MEDICAL DETAILS / HISTORY	Yes	Details
Do you have any genetic / hereditary illness?		
Present State of Health		
CANCER?		
UNDIAGNOSED LUMPS		
Contagious Disease?		
Are you on any medication?		
Muscular / Skeletal:		
OSTEOARTHRITIS - POROSIS		
RHEUMATOID ARTHRITIS		
POSTURAL DEFORMITIES		
WHIPLASH/SLIPPED DISC		
Recent operations? 2yrs – 6mths		
Recent fractures? (3 months)		
Headaches		
Muscular Aches (see chart)		
Circulation:		
HEART PROBLEMS		
THROMBOSIS		
KIDNEY PROBLEMS		
HAEMOPHILIA		
DIABETES		
High / Low Blood Pressure		
Fluid Retention		
Varicose Veins		
Bad Circulation - cold hands/feet		

Allergies:	Yes	Details
Food (incl NUTS)		
ASTHMA		
Other		
Immune System:		
Prone to Infections		
Sore Throats / Regular Colds		
Gynaecological:		
Are you PREGNANT		How many weeks
Irregular Periods		
Menopause		
Pill / hormonal implants		
Nervous System:		
EPILEPSY		
MS		
ME		
MOTOR NEURONE DISEASE		
PARKINSONS DISEASE		
BELLS PALSY		
TRAPPED/INFLAMED NERVE		
Migraines		
Depression		
Stress		
Skin:		Dry / Normal / Oily
Conditions-cuts, bruises, burns		
Melanomas		
Verucas or warts		
Digestion:		
Irritable Bowel Syndrome		
Ulcers		
Other		
Please give details of any other problems that may be relevant.		

LIFESTYLE	
Exercise	Regular / Occasional [delete if n/a]
Type of Exercise	
Your Sleep Pattern	Good / Poor How many hours?
Ability to relax	Easy / Average / With difficulty

Disclaimer

Please read carefully & only initial 1, 2 or 3 & sign below if you are in full agreement with its contents, & that the medical history is true.

1) I _____ confirm that I have understood the treatment that I don't have anything being treated/ am on no medication and consent to treatment .

OR

2) I _____ confirm that I have understood the treatment & given my medical history I have gained the approval of my GP and Consultant prior to receiving the treatment. It is not the responsibility of your therapist to consult your GP or Consultant.

I hereby indemnify the therapist against any adverse reaction sustained as a result of the treatment

I understand that treatments which are cancelled less than 24 hours of their appointment will be charged in full.

Client Signature.....parent/ guardian signature..... Date.....

Therapist Signature..... Date.....