

CONSULTATION FORM

Client Note:

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	2							
Address:								
No. of Children:	Date of Birth:							
Profession:	Phone No:							
E-mail:								
GP name and address:				• • • • • • • • • •				
Contraindications	roquiring modic	al narmissi	ion. In aircur	ngtangag	yyhara ma	idiaal nar		
	•	-				_		
mission cannot be obta	ained client must give	e informed co	onsent in Writi	ng prior	to treatme	nt.		
Slipped disc □ Astl	hma □ Medical oe	edema 🗆 🗆	Epilepsy □	Bell's F	Palsy □	Cancer		
Haemophilia □ Arth	nritis Kidney inf	ections	Whiplash □	Inflame	ed nerve 🗆			
Osteoporosis Dia	betes Acute rheu	ımatism 🗆	Pregnancy	Spastic	condition			
Postural deformities	Nervous/Psychoti	c conditions	□ Trapped/	Pinched	nerve (e.g.	. sciatica) 🗆		
Cardio vascular condit	ions (thrombosis	s, phlebitis, h	igh or low blo	ood press	sure, heart	conditions)		
Nervous system dysfur	nction (Muscula	ar sclerosis, P	arkinson's dis	sease, M	otor neuro	ne disease)		
Undiagnosed pain □								
Recent operations								
Other condition hairs	tracted by CD on one	th an a amount am	- ou tour : the outour	.i.4.				
Other condition being Prescribed medication:	-	*						
Prescribed medication:	· · · · · · · · · · · · · · · · · · ·		•••••		• • • • • • • • • • • • • • • • • • • •			
Localised Contrai	ndications:							
Localised swelling	Inflammation	Sunburn	Varicose v	eins 🗆	Hormonal	implants \square		
Cervical spondylitis	Haematoma □	Hernia □	Gastric ulc	ers 🗆	Cuts/Bruis	ses □		
Recent fractures (minin	mum 3 months) □	Undiagnose	ed lump/bump	os 🗆				



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		mach	Liver/Gall bladder □				
Circulation: Cold hands and feet \Box	Cellulite	□ Tire	d legs □	Kidney problems □				
Nervous system: Headaches □	Migraine □	Tension	□ Stres	s Depression				
Immune system: Sore throat □	Sinuses □	Colds \Box	Chest □	Prone to infection				
Gynaecological: Menopause	H.R.T □	P.M.T □	Pills □	Irregular periods □				
Coil □	Coil □ Other □		Date of l	Date of last period:				
Aids or STD:								
Current homeopathic, vitamins supplements, etc:								
How would you describe your diet? (Portions/cups a day)								
Veg/Fruit Dairy Produce Sweet Things Protein cont. food								
Tea Coffee Water Soft Drinks Other								
Eating in a hurry □ Regular meals □ Overeating □ Allergies □								
Do you smoke? No □ Yes □ average per day:								
Do you drink alcohol? No □ Yes □ average consumption daily/weekly:								
General state of health:								
Stress levels: home: High Medi	um 🗆 Low 🗆	w	ork: High □	Medium □ Low □				
Sleep pattern: Good Average Poor Ability to relax: Good Average Poor								
Working at computer: No □ Yes □ (hours daily/weekly)								
Hobbies/relaxation activities:								
Have you had a Complementary Treatment before? No □ Yes □ (recently?)								
Reason for seeking treatment:								

Client declaration:

I declare that the information I have given is correct and that as far 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. 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 medical treatment. I agree that my data can be securely stored by A'INE Complementary Therapies, who will not share data with third parties without prior consent. Client Signature: Date: LAVA SHELL MASSAGE, HOT STONES MASSAGE and THAI HOT HERBAL COMPRESS MASSAGE The treatment CANNOT be carried on the following: Sensitivity or intolerance to heat □ Conditions aggravated heat □ Medications that may have side effects to heat

..... Client Signature: Date: INDIAN HEAD MASSAGE The treatment CANNOT be carried on the following: Sycosis barbae □ Impetigo □ Ringworm □ Conjunctivitis □ Scabies □ Vertigo □ Head lice ⊓ Current earache □ Cold sores □ Recent head or neck injury Client Signature: Date: **AROMATHERAPY Contraindications that restrict treatment:** Hypersensitive skin □ Breast feeding □ Client Signature: Date: HOPI EAR CANDLING The treatment CANNOT be carried on the following: 1st trimester of pregnancy □ Auricular Cysts □ Acute Mastoiditis Ear Tumour Perforated Ear Drum Otosclerosis or Otospongiosis (ankylosis of the stapes) Ventilation tubes, Auricular drains (Paracentesis or Grommets) The treatment is not advisable where there is: Infection or irritation □ Chest infection □ Previous allergic reaction □ Swelling or inflammation □ Recent head or neck injury □ Bad cough or cold □ Severe bruising, recent injury or any skin disorder in the area to be massaged \(\sigma\) If oil has been used in the ears within last 24 hours Client Signature: Date: