CONSULTATION FORM

Advanced Clinical Massage

Date of consultation: ……

PERSONAL DETAILS

Title: …… Name ……..……

Address: ……..……...

..…… Postcode:…….……

No. of Children:…….…...…..……...… Date of Birth: ……..……..……

Profession: ……..……..……... Phone No: …….……..……

E-mail: ……..……..……..…….

GENERAL HEALTH

Cardio vascular conditions (high/low blood pressure, etc.):……..…...…..

Nervous system dysfunction (Motor neurone disease, etc.):……..…….

Muscular/Skeletal problems:……...……...……...……

Digestive problems:……..……

Immune system (Sinuses, prone to infection, etc.):…….……...……..

Gynaecological:…….

History of use of contraception:…….

Swelling or inflammation ☐ Varicose veins ☐ Hernia ☐ Slipped disc ☐ Epilepsy ☐

Pregnancy ☐ Whiplash ☐ Osteoporosis ☐ Diabetes ☐ Trapped/pinched nerve ☐

Aids or STD: ……...…….

Recent injury or operation……..……

Condition being treated by GP:……..……

Other complementary therapy:……...

Prescribed medication or homeopathic:……..……...

Medication that may have side effects to heat: …….

Other: ……..……

Address: 5 Earlspark Crescent, Bieldside, Aberdeen, AB15 9AY
Website: www.ainetherapies.co.uk E-mail: info@ainetherapies.co.uk
Mobile: 07798 557454

DIET AND HEALTH STYLE

DESCRIBE YOUR DIET (Veg/fruit, dairy produce, sweets, protein cont. food)…….

……
……
……
ALCOHOL: ……units/week
TEA: black: …… green: …… white: ……. cups/day
COFFEE: ……..… cups/day
LOW FAT DIET: yes …….. No …….. Trying ……..

INTOLERANCE and ALERGY ……...……
VITAMINES/MINERALS SUPPLEMENTS ……..…….
VEGETARIAN/VEGAN or other ……...……..
ORGANIC FOOD ……
SENSITIVITY TO HEAT/COULD……..…
SENSITIVITY TO ESSENTIAL OILS to be used today……..

EXERCISE: ……...……
SMOKING: yes …….. No …….. Trying to stop ……..
STRESS: at work: yes …….. No ……..
at home: yes …….. No ……..
How do you manage stress?……
SLEEP PATERN: Good □ Average □ Poor □ How many hours, waking up?…….
ABILITY TO RELAX: Good □ Average □ Poor □

WORKING AT COMPUTER: No □ Yes □ (hours daily) ……..…

Other comment: ……..……...
……
……

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: ……..…….

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The reason for coming for a treatment: ……

How would you like to feel after the treatment: ……..……....

When the pain begin (after accident, emotional trauma, etc.)**?**.....

What makes the pain better? .....

What makes pain worse? ……......

Does the pain radiate to different parts of the body?……...

The quality of pain? (circle) Tingling or electric, sharp and stabbing, dull and achy, deep and constant.

The scale of the pain at the moment? 1 to 10 (10 highest)…….

The scale of the pain historically? 1 to 10 (10 highest) …….

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