Consultation Form

BODY TREATS
relax . revive . rebalance

Personal Details

Mr/Mrs/Miss/other:_____Forename:_____Surname:_____

Address:_____

_____Postcode: _____

Phone:(H)_____(M)_____(W)_____

Email address: _____

D.O.B: _____/_____/_____ Occupation: _____

Doctor: _____ Practice address:_____

_____

General state of health

Do you exercise regularly: Yes/No Are you taking any medication: Yes/No (Provide details)

Are you on a special diet: Yes/No Do you drink alcohol: Yes/No Units per week:_____

Do you smoke: Yes/No No. per week:_____

Could you be pregnant? Yes/No No. of months:_____

How would you describe your stress levels: Low Medium High

How would you describe your energy levels: Low Medium High

How would you describe your sleep patterns:_____

What do you do for relaxation?:_____

Have you had a treatment before?: Yes/No Reason for today's treatment:_____

Conditions and/or symptoms

Please check the information below and circle any that apply. Please give further details in the space provided below. Those with an asterisk are important to Hopi Ear Candle treatments.

Unstable blood pressure	Heart disorders	Thrombosis/ embolism	Epilepsy	Allergies
Infectious diseases	Skin disorders	Severe bruising	Recent scar tissue	Back problems
Fractures or sprains	Swelling//Oedema	Cuts or abrasions	Varicose veins	Diabetes
Osteoporosis	Haemorrhage	Inoculations	Cancer	Arthritis
Recently eaten a heavy meal	Neck/head injury*	Recently consumed alcohol*	Recent operations*	Fever/illness*
Meningitis/loss of skin sensation*	Perforated ear drum*	Inflammation/infection in ear*	Headache/migraine*	Grommets*

Medication/Condition details:

Client's signature:_____ Date:_____

Therapist's signature:_____ Date:_____