Consultation Form

Date: …….. Patient No. ……..

Surname: …… Forename: …… DOB: ……. Age: ……

Address: …… Home Tel: …….
…… Work Tel: ……..
…… Mobile: ……..

Sex: …….. Marital Status: …….. Children: ……

Email Address: …….. Ages: ……..

Occupation: ……

Doctors Name: ……... Tel: …….

Doctors Address: ……
……

Have you had or are you suffering from Cancer? Yes/No

Do you have allergies to?

Nuts/Oils	Yes/No
Hayfever	Yes/No
Sinusitis	Yes/No
Eczema	Yes/No
Psoriasis	Yes/No
Any other Known	Yes/No

Are you?

Diabetic	Yes/No
Epileptic	Yes/No
Are you wearing	
Contact Lenses	Yes/No

Are you/could you be pregnant? Yes/No **Date of LMP: ……**

Do you suffer from/or have any of the following?

Heart Problems	Yes/No	Kidney	Yes/No
High Blood Pressure	Yes/No	Indigestion	Yes/No
Varicose Veins	Yes/No	Gallstones	Yes/No
Multiple Sclerosis	Yes/No	Constipation	Yes/No
Arthritis	Yes/No	Diarrhoea	Yes/No
Rheumatism	Yes/No	Asthma	Yes/No
Broken Bones/Strains	Yes/No	Eye Problems	Yes/No
Recent Scar Tissue	Yes/No	Ear Problems	Yes/No
Menstruation	Yes/No	Migraine	Yes/No
Birth Pill	Yes/No	Headaches	Yes/No
PMT	Yes/No	Insomnia	Yes/No
Menopausal	Yes/No	Nervous Stress	Yes/No
Anxiety	Yes/No	Depression	Yes/No

Spinal

Posture	Yes/No	Neck	Yes/No
Shoulders	Yes/No	Lumbar	Yes/No
Back	Yes/No		

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Recent Operations? …….....

Do you have any other medical condition/illness?

……..

Are you on any medication?

……..

Are you intending to sunbathe or use a sunbed within the next 24 hours? Yes/No

Do you?

Take Supplements	Yes/No	…….
Smoke	Yes/No	How many per day? …….....
Drink alcohol	Yes/No	Units per week? ……..

Approx how much fluid do you take each day? ……

Exercise Yes/No Type: ……..

How much training per week? ……

Is there any other heath condition, which you think would affect you having therapy?
…….

Some Clients may have the following symptoms for up to 48 hours after a therapy. Headaches, Emotionally Upset, Lethargic, Energized, Flu Like, Achy. This is a result of your mind and body absorbing the essential oils.

Disclaimer

I have answered the questions truthfully. I understand the therapist has gone through this consultation with me, to identify if there are any contra-indications that would affect me having a treatment. I also understand that this is to safeguard me as well as the therapist. I therefore do not hold the therapist KAMILA GLASEK liable.

Client Signature: …….

Client To Print Name: ……..

Date: ……