Holyrood Holistic Consultation Form (Annual)

Client Name:
Address:

Tel. No: Day
Eve

Profession:

PERSONAL DETAILS

Age group: Under 20 20–30 30–40 40–50 50–60 60+

Lifestyle: Active Sedentary

Last visit to the doctor:

Last visit to a complementary therapist:

GP address:

No. of children and age, or caring for someone (if applicable):

Date of last period (if applicable):

CONTRAINDICATIONS REQUIRING MEDICAL PERMISSION – in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment. ***(please circle if/where appropriate):***

Pregnancy
Cardio vascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions)
Haemophilia
Any condition already being treated by a GP or another complementary practitioner
Medical oedema
Osteoporosis
Arthritis
Nervous/Psychotic conditions
Epilepsy
Recent operations
Diabetes
Asthma
Acute rheumatism
Any dysfunction of the nervous system (e.g. Multiple sclerosis, Parkinson’s disease, Motor neurone disease)
Bell’s Palsy
Trapped/Pinched nerve (e.g. sciatica)
Inflamed nerve
Cancer
Postural deformities
Cervical spondylitis
Spastic conditions
Kidney infections
Whiplash
Slipped disc
Undiagnosed pain
When taking prescribed medication

CONTRAINDICATIONS THAT RESTRICT TREATMENT ***(please circle if/where appropriate):***

Fever
Contagious or infectious diseases
Under the influence of recreational drugs or alcohol
Diarrhoea and vomiting
Skin diseases
Undiagnosed lumps and bumps
Localised swelling
Inflammation
Varicose veins
Pregnancy (abdomen)
Cuts
Bruises
Abrasions
Scar tissue (2 years for major operation and 6 months for a small scar)
Sunburn
Hormonal implants
Abdomen (first few days of menstruation)
Haematoma
Hernia
Recent fractures (minimum 3 months)
Gastric ulcers
After a heavy meal
Conditions affecting the neck

WRITTEN PERMISSION REQUIRED BY ***(please circle if/where appropriate):***

GP/Specialist Informed consent
Either of which should be attached to the consultation form.

PERSONAL INFORMATION *(select if/where appropriate)*:
Muscular/Skeletal problems: Back Aches/Pain Stiff joints Headaches
Digestive problems: Constipation Bloating Liver/Gall bladder Stomach
Circulation: Heart Blood pressure Fluid retention Tired legs Varicose veins
Cellulite Kidney problems Cold hands and feet
Gynaecological: Irregular periods P.M.T Menopause H.R.T Pill Coil Other
Nervous system: Migraine Tension Stress Depression
Immune system: Prone to infections Sore throats Colds Chest Sinuses
Any recent (five year) medical (hospitalisation, illness, breakages etc):

Any other health disorders: Respiratory conditions High cholesterol Hormonal problems Allergies Cellulite
Any additional conditions/symptoms not mentioned above:

Do you use: Implants or pacemaker Dentures or contact lenses
Ability to relax: Good Moderate Poor
Sleep patterns: Good Poor Average No. of hours
Do you see natural daylight in your workplace? Yes No
Do you work at a computer? Yes No If yes how many hours?
Do you eat regular meals? Yes No
Do you eat in a hurry? Yes No
How many portions of each of these items does your diet contain per day?
Fresh fruit: Fresh vegetables: Protein: source?
Dairy produce: Sweet things: Added salt: Added sugar:
How many units of these drinks do you consume per day?
Tea: Coffee: Fruit juice: Water: Soft drinks: Others?
Do you suffer from eating disorders? Bingeing? Yes No Overeating? Yes No
Under eating? Yes No
Do you smoke? No Yes How many per day?
Do you drink alcohol? No Yes How many units per day? or per week?
Do you exercise? None Occasional Irregular Regular Type of exercise:
What do you like to do in your spare time?
How do you manage stress in your life? What helps you to relax?
Where do you feel stress in your body? (eg. jaw, stomach, shoulders?)
Any procedures I should know about in case of an emergency (eg if diabetic or epileptic, what procedure should be taken if an attack happens)?

Stress level: 1–10 (10 being the highest)
At work: At home:

Please confirm the above information is correct (please be aware that all client information is confidential and kept securely)

Signed.. Date ....

Confidentiality clause
Gabe Stewart further agrees to treat all information relating to or resulting from any treatments provided by Holyrood Holistic as absolutely confidential. Gabe Stewart shall not disclose anything regarding any client's treatment to any other person or entity, unless legally compelled to do so, and then, only upon timely prior notice to the client, giving the client sufficient time to contest any such disclosure.

Signed and dated...................................... Gabe Stewart, massage therapist and owner of Holyrood Holistic