AthenaHolistics

Client Consultation Sheet

Name:.....**Age**.....

Address:.....

Post Code:.....Email:.....

Doctors name & address:.....**Tele No**.....

Client Reason for Treatment:.....

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Medical Background:

Recent head or neck injury	Yes/No(if yes please give detail below)
Recent surgery	Yes/No
Suffer from ear infection now or in past	Yes/No
Inflammation in ear	Yes/No
Do you have grommets fitted	Yes/No
Perforated ear drum	Yes/No
Epilepsy	Yes/No
High or Low blood pressure	Yes/No
Circulatory disorders	Yes/No
Dysfunction of nervous system	Yes/No
Allergies (including products)	Yes/No
Headaches/migraines	Yes/No
Eczema	Yes/No
Currently taking any medication	Yes/No
Pregnancy	Yes/No
Are you under the influence of drugs/alcohol	Yes/No

Do you drink alcohol: Yes/No How many unit's .....

Do you smoke: Yes/No How many per day.....

Are there any reasons that you are aware of preventing you from having this treatment Yes/no.....

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Extra Details:.....

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I would like to receive the following therapy treatment:.....

I confirm that the information given is correct an as far I am aware I can undertake treatment without any adverse effect and that I do not require my doctors permission. I have been fully informed about contra-indications and therefore I am willing to proceed with the treatment.

Clients signature.....Date.....

Therapist's signature.....Date.....