On-site Relaxation Ltd CONSULTATION FORM

Name: ……Tel no (*work*):……..*(home):*…….…. *(mobile):*……..

Date of birth: …….. Occupation: ……..

Address: …….
……

Reason for visit: ……

When did this condition start?……

Is there anything that makes your condition worse?…….. ……
or better?……..

Is your condition result of an accident?: …… Is litigation involved:……..

Have you received previous treatment for this condition?……. If yes, please explain…….

……

Doctor's name:…… Practice/address:……
…….Phone no: ……

Do you have children?… ……. Are they well?……
Are you pregnant?…… When is the baby due…….
Do you smoke?……. How many per day? …….

Please tick if any of these conditions apply to you: -

	allergies		chest pain		hands cold/numb		pregnancy
	anxiety		constipation		headache		sight problems
	arthritis		depression		heart problems		sinusitis
	asthma		diabetes		indigestion		skin problems
	back pain		diarrhoea		infection(s)		skin disorders
	blood clots		difficulty swallowing		joint pains		sleep problems
	blood pressure-high		dizziness		migraine		sciatica
	blood pressure - low		ears 'glue ear'		neck pain		tiredness
	breathing problems		ears ringing		numbness		urinary problems
	broken bones		epilepsy		operations		varicose veins
	cancer		feet cold or numb		period problems		weight loss

……
……
……
Is there anything else you think I should know?……If yes, please specify……...
……...
……
Have you been X-rayed or scanned recently?…….If yes, when, where and why?……
……
……

I have stated all my known medical conditions, in confidence, and take it upon myself to keep the Therapist updated on my physical health. I consent to this consultation, assessment and treatment which will involve soft tissue techniques.

Signed:…… **Date:** ……..

Operations: ……..
……..
……..

Fractures:……..……
……..

Accidents: ……
……..

Pregnancies/Births: ……

Health problems: ……
……
……

Stress level: *(scale of 0 - 10 (0 none/10 very high)*……

Medication/supplements/homeopathic remedy: ……
……..
……..

Any other relevant medical history:……
……..

Any relevant social/family history:……...
……..

Sport/exercise?……..……...

Weight (*under / OK / over)*……..……..

Previous treatment: ……..
……..

Scans/X-rays……

Primary complaint: ……
……...

Any other complaints/relevant information ……
……..
……..

Examination:

Note areas of pain / paraesthesiae