**Health Questionnaire (Detailed) and Consent Form for**

**Holistic Therapies**

|  |  |  |  |
| --- | --- | --- | --- |
| **All information is held in strict confidence** | | | |
| **Your Contact Details** | | | | |
| **Surname** |  | **Date of Birth** |  | |
| **First name** |  | **Contact Number** |  | |
| **Address and Post Code** |  | | | |
| **Emergency Contact Details** | | | | |
| **Surname** |  | **Contact Number** |  | |
| **First Name** |  | **Relationship** |  | |

**Do any of these health conditions apply to you?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **No** | **Yes** | **If yes, please provide details** |
| **Arthritis** |  |  |  |
| **Back Problems** |  |  |  |
| **Breathing Problems** |  |  |  |
| **Depression** |  |  |  |
| **Diabetes** |  |  |  |
| **Eye Problems** |  |  |  |
| **Heart Problems** |  |  |  |
| **High/Low Blood Pressure** |  |  |  |
| **Knee Problems** |  |  |  |
| **Neck Problems** |  |  |  |
| **Pregnancy** |  |  |  |
| **Recent Fractures/Sprains** |  |  |  |
| **Recent Surgery** |  |  |  |
| **Allergies** |  |  |  |
| **Other issues** |  | | |

**I will immediately inform my therapist/practitioner/trainer of any change in my medical status.**

**Consent**

I have, following consultation, consideration, and discussion, agreed to undergo this therapy. I am fully aware that the services I wish to receive are those of a holistic nature and do not serve as a substitute for professional medical advice, examination, diagnosis, or treatment.

I understand the information I have been given to be true and I consent to the following treatment:

|  |
| --- |
|  |

**Important Information**

The proposed procedure has been explained to me in detail and I understand the nature of the treatment. I also understand this treatment is not a substitute for medical treatment and it may take several sessions before I notice any benefit. This will depend on my lifestyle, on-going medication and general health.

I understand that if I have been untruthful with any details provided or have failed to give enough relevant information -

* the outcome of any therapy/treatment/class could be adversely affected and
* my health and well-being may be put at risk.

I understand the therapist/practitioner/trainer does not claim to cure or to diagnose any medical condition in the same way as a doctor/physician. Their opinion is that of a holistic, complementary, and alternative therapist and their professional opinions, advice, examinations, and recommendations do NOT constitute the medical advice of a doctor/physician.

I confirm that I have given my personal details for the therapist’s/practitioner’s/teacher’s use in connection with the therapy/treatment/class and consent to the storage of these details for at least ten years. (We are unable to provide any therapy/treatment/class without your consent.)

I confirm that you may retain this information so that you can contact me again in the future. I understand that open/group activities may be recorded, and any material collected may be shown on Social Media pages such as LinkedIn and Facebook

|  |  |
| --- | --- |
| **Client Signature** |  |
| **Date Signed** |  |

**Insurance**

Your Teacher/Trainer is a member of [Foyht](https://foyht.org/), who recommend BGi.uk, BGi.eu and Hispania for bespoke Malpractice Liability Insurance