Holistic Therapies Health Questionnaire and Consent Form

All information is strictly confidential

Name:		Mobile:	
Home Tel:		e-mail:	
Address:			
		Post Code:	
Date of Birth:			

Do any of these health conditions apply to you?	Yes	No	If yes, please give 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 Operations	○	○	
Other	○	○	

I will immediately inform my therapist/practitioner/trainer of any changes to my medical status.

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I have, following consultation, consideration and discussion, agreed to undergo this therapy. I am fully aware that the services I ǿlǎK ű2 receive are those of a holistic nature and do not serve as a substitute for professional medical advice, examination, ŘʌI·Ǝy2ǎʌǎ 2ℕ treatment.

I understand the information I have been given to be the truth and consent to the treatment of

I have had the procedure explained to me and understand the nature of the treatment. I fully 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 life ǎűèfŜΣ 2yπƎ2ʌyƎ medication and general health.

I understand that if I have been untruthful with my details 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 l· doctor/physician. Their opinion is that of a holistic, complementary and alternative therapist and their professional opinions, l·ŘØʌǑŜΣ 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 űŜy 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 l·ă Facebook

Client Signature: Date:

Notes: