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.

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 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 style, on-going 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 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 Facebook

Client Signature: Date:

Notes: