

Consultation Form



Client Information	
Client Name:	GP Practise:
Address:	Address:
Mobile No.:	
Email:	Tel. No.:
Date of Birth:	Permission to contact: YES / NO

Occupation	
Occupation:	
Full Time or Part Time:	Shift Pattern: YES / NO
Please advise whether your job requires you to sit for long periods: YES / NO	

Stress Levels	
<i>On a scale of 0-10 (0 being low & 10 being high) please indicate your stress levels for the following:</i>	
Please indicate your overall / average stress levels:	
Please indicate how stress manifests in you (i.e. tension in shoulders, headaches, anxiety, irregular sleep, digestion issues):	

Lifestyle Overview				
<i>Please indicate the average for the following:</i>	Daily	Weekly	Monthly	None
How often do you consume alcohol?				
How often do you smoke?				
How often do you exercise?				
How often during the week you take 'time out' to relax i.e. a walk, reading, taking a bath:				
Please indicate how many glasses / litres of water you consume daily:				
Please indicate how many cups of tea / coffee you consume daily:				
Please detail any known intolerances:				
Please detail any known allergies:				

Consultation Form

Current Conditions
Please give details of any illnesses, infectious diseases or disorders you have:
Please detail any medication you are currently taking and for what condition:
Please detail any side effects of said medication:
Please detail any accidents, injuries or operations which have taken place in the past 12 months:

Health Overview					
<i>Please indicate any known issues or if suffer with any of the following:</i>					
Musculoskeletal	Yes	No	Dermatological	Yes	No
Spine / Back Pain			Dermatitis / Eczema		
Osteoporosis			Cold Sores		
Arthritis			Acne Boils		
Joint Problems			Psoriasis		
Muscular Problems			Skin Disorders		
Rheumatism			Fungal Conditions		
Teeth					
Frozen Shoulder					
Metal Pins / Plates					
Cardiovascular	Yes	No	Gynaecological	Yes	No
Palpitations			Irregular Periods		
Pace Maker			Bloating		
Heart Problems / Conditions			PMT		
Varicose Veins			Endometriosis / Ovarian Cysts		
DVT					
Irregular Blood Pressure					
Respiratory	Yes	No	Nervous System	Yes	No
Asthma			Insomnia		
Breathlessness			Drowsiness		
Bronchitis			Excessive Sweating		
Emphysema			Mood Swings		
Sinusitis			Headaches / Migraines		
Urogenital	Yes	No	Gastrointestinal	Yes	No
Kidneys			Indigestion		
Cystitis			Constipation		
Fluid Retention			Diarrhoea		
Endocrine	Yes	No	Other	Yes	No
Thyroid Condition			Cancer		
Diabetes			Epilepsy		
Please provide further information for any in which you have answered 'Yes':					

Consultation Form

Cosmetic Surgery			
<i>Please indicate whether you have undergone any of the following within the time periods stated.</i>	4 weeks	6 months	12 months
Face Lift:			
Facial Fillers:			
Botox:			

Female Clients Only			
	Yes	No	Duration
Could you be pregnant:			
Are you currently breast feeding:			
Are you taking any form of contraception:			
Please advise if you have started menopause:			

Treatment
Please advise the reason you wish to have your chosen treatment:
Please advise your desired outcome of the treatment:

I confirm that the above information is true to the best of my knowledge. I understand that if I have any of the above conditions or health concerns it is my responsibility to consult with my GP before treatment and obtain consent. Otherwise, I confirm that I am willing to proceed without consulting my GP and hereby indemnify Sally Rall against any adverse reaction sustained as a result of treatment:

Client Signature:

Date:

I acknowledge by signing this form that I agree to the GDPR Policy and Term's & Condition's.