Consultation Form

HOT STONE THERAPY TREATMENT

Client Name:	
Profession:	
GP Address:	
Last Visit to the Doctor:	

CONTRAINDICATIONS THE REQUIRE MEDICAL PERMISSION

In circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment. (*Select where appropriate):*

- ☐ Pregnancy
- ☐ Recent Operations
- ☐ Asthma
- ☐ Postural Deformities
- ☐ Diabetes
- ☐ Haemophilia
- ☐ Medical oedema
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Anxiety/Stress/Depression
- ☐ Epilepsy
- ☐ Bell's Palsy
- ☐ Thyroid Disorders
- ☐ Inflamed Nerve
- ☐ Slipped Disc
- ☐ Undiagnosed Pain
- ☐ Acute Rheumatism
- ☐ Kidney Infections
- ☐ Cervical Spondylitis
- ☐ Cancer
- ☐ Taking Prescribed Medication
- ☐ Whiplash
- ☐ Spinal Cord conditions e.g. Cerebral Palsy
- ☐ Trapped/Pinched Nerve e.g. Sciatica
- ☐ Cardiovascular conditions e.g. Thrombosis, Phlebitis, Hypertension, Hypotension, Heart Conditions
- ☐ Any condition already being treated by a GP or another health professional, e.g. Physiotherapist, Osteopath, Chiropractor, Coach
- ☐ Severe Allergies (that require medical attention e.g., nuts)

PLEASE GIVE DETAILS OF ANY OTHER DIAGNOSED MEDICAL CONDITION THAT IS NOT LISTED ABOVE:

CONTRAINDICATIONS THAT RESTRICT TREATMENT
(*Select if/where appropriate):*

☐ Fever ☐ Cuts ☐ Bruises

☐ Abrasions ☐ Diarrhoea and Vomiting ☐ Sunburn

☐ Skin Diseases ☐ Undiagnosed Lumps & Bumps ☐ Localised Swelling

☐ Varicose Veins ☐ Pregnancy (abdomen) ☐ Hormonal Implants

☐ Haematoma ☐ Hernia ☐ Gastric Ulcers

☐ After a Heavy Meal ☐ Conditions affecting the neck ☐ Menstruation (abdomen – 1st few days)

☐ Cervical Spondylitis ☐ Cancer ☐ Taking Prescribed Medication

WRITTEN PERMISSION REQUIRED BY GP/SPECIALIST
(If any of the boxes above are ticked, a disclaimer form should be completed by the client and attached to the consultation form)

☐ Yes ☐ No

PERSONAL INFORMATION
(*Select if/where appropriate):*

Muscular/Skeletal Problems

☐ Back ☐ Aches/Pain ☐ Stiff Joints ☐ Headaches

Digestive Problems

☐ Constipation ☐ Bloating ☐ Liver/Gall Bladder ☐ Stomach

Circulation

☐ Heart ☐ Blood Pressure ☐ Fluid Retention ☐ Tired Legs ☐ Varicose Veins

☐ Cellulite ☐ Kidney Problems ☐ Cold Hands & Feet

Gynaecological

☐ Irregular Periods ☐ P.M.T. ☐ Menopause ☐ H.R.T. ☐ Pill

☐ Coil ☐ Other

Nervous System

☐ Migraine ☐ Tension ☐ Stress ☐ Depression

Immune System

☐ Sore Throats ☐ Colds ☐ Prone to Infections ☐ Chest ☐ Sinuses

Regular Antibiotic/Medication Taken? ☐ Yes ☐ No

If yes, which ones:

Herbal Remedies Taken? ☐ Yes ☐ No

If yes, which ones:

Ability to Relax ☐ Good ☐ Moderate ☐ Poor

Sleep Patterns ☐ Good ☐ Moderate ☐ Poor

Do you see natural daylight at work? ☐ Yes ☐ No

Do you work at a computer? ☐ Yes ☐ No

If so, how many hours:

Do you eat regular meals? ☐ Yes ☐ No

Do you eat in a hurry? ☐ Yes ☐ No

Do you take any food/vitamin supplements? ☐ Yes ☐ No

If yes, which ones:

What do you eat for…

Breakfast:	
Lunch:	
Dinner:	

Do you eat (regularly): ☐ Sweet Things ☐ Added Salt ☐ Added Sugar

Do you restrict any food groups? ☐ Yes ☐ No

If so, what:

How many units of drinks do you consume per day?

☐ Tea ☐ Coffee ☐ Fruit Juice ☐ Water ☐ Soft Drinks

☐ Other

Do you suffer from food allergies? ☐ Yes ☐ No

If yes, which ones:

Does stress affect your eating habits? ☐ Yes ☐ No

If so, how:

Do you smoke? ☐ Yes ☐ No **How may per day?**

Do you drink alcohol? ☐ Yes ☐ No **Units per week?**

Do you exercise? ☐ None ☐ Occasional ☐ Irregular ☐ Regular

Type:

What's your skin type?

☐ Dry ☐ Oily ☐ Combination ☐ Sensitive ☐ Dehydrated

Do you suffer from?

☐ Dermatitis ☐ Acne ☐ Eczema ☐ Psoriasis ☐ Allergies
☐ Hay Fever ☐ Asthma ☐ Skin Cancer

Do you suffer from allergic skin reactions? ☐ Yes ☐ No

If so, to what:

Stress Level 1-10 (10 being the highest) ☐ At Work ☐ At Home

☐ Right-Handed ☐ Left-Handed

TREATMENT PLAN:

HOME CARE / AFTERCARE ADVICE:

CLIENT FEEDBACK:

HOW YOUR INFORMATION WILL BE USED

We take your privacy very seriously; your personal information will only be used for treatment purposes and will never be shared with any third parties without express permission.

KEEPING IN TOUCH

From time to time, we would like to get in touch with you when we have information about new therapies and special offers that we think might be of interest to you. If you agree to being contacted in this way, please tick how you are happy to be contacted:

☐ Post ☐ Email ☐ Phone ☐ SMS ☐ None

If you have ticked one or more boxes above, please note that you can change your preferences or remove your consent at any time by getting in contact with us.

By signing below, you agree that your medical history is accurate and correct, and you agree to all the above statements.

Client's Signature:	
Therapist's Signature:	
Date:	

Treatment Continuation

HOT STONE THERAPY TREATMENT

Client Name:	
Treatment Date:	

TREATMENT PLAN:

HOME CARE / AFTERCARE ADVICE:

CLIENT FEEDBACK:

Client's Signature:	
Therapist's Signature:	
Date:	