**HOLISTIC THERAPY CONSULTATION FORM**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No.& Age of Children \_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_ Pregnant: N / Y \_\_\_\_\_\_\_\_\_\_ weeks

GP address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Profession: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact (if required): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any other therapies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Medical History, Operations, Scans and X-Ray's: |
| Medication & Supplements: |
| Present Health: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Neck Pain |  | Depression |  | Varicose Veins |  |
| Back Pain |  | Eczema  |  | Kidney |  |
| Other Pain  |  | Constipation |  | Circulatory |  |
| Stiff Joints |  | IBS |  | PMT |  |
| Whiplash |  | Digestion |  | Menopausal  |  |
| Rheumatism  |  | Liver |  | Postnatal  |  |
| Migraines |  | Blood Pressure |  | Diabetes |  |
| Headaches |  | Fluid Retention |  | Cough/Cold |  |
| Stress |  | Allergies |  | Asthma |  |
| Anxiety |  | Psoriasis  |  | Fungal Con. |  |
| Insomnia  |  | Epilepsy |  | Cancer  |  |

I would like to assure you that your personal information will be stored securely, remain confidential and will only be used for treatment purposes and therefore not be shared with any third parties without express permission.

I would like to keep in touch with you regarding new treatments and special offers that I may think might be of interest to you. If you would like to receive these emails please tick here 🔲

Please note that your data will only be used to send you information from Joanna Anderson and will not be shared with any other third parties or agencies. You can change your preferences or remove your consent at any time by contacting jo@joanna-anderson.co.uk

Declaration: I here by agree, that all the above information is accurate at time taken and I fully consent to and understand the treatment.

Clients signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapists signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_