Clarice House, Bramford, Ipswich IP8 4AZ
01473 463262

CLIENT CONSULTATION FORM

Note

The following information is required for your safety and to benefit your health. The following details will be treated in the strictest of confidence. If you are or have suffered from any of the following: epilepsy, thrombosis, embolism, cancer or diabetes, it will be necessary for you to obtain the approval from your GP prior to treatment.

Minors under the age of 16 - Any child under the age of 16 needs to be accompanied by an adult for treatments and the consultation form must be signed by the main care-giver.

Title: ______ **Forename:** ______ **Surname:** ______

Address: ______

Post Code: ______ **Date of Birth:** ______

Home Tel. No.: ______ **Other Contact No.:** ______

Email: ______

GP Address: ______

Date of Consultation: ______

MEDICAL HISTORY

Do you have or have you ever suffered with any of the following:

	Yes	No		Yes	No
Heart condition / valve dysfunction			Circulatory disorder		
High or low blood pressure			Diabetes		
Tumours or unrecognisable lumps			Epilepsy		
Varicose veins or varicose ulcers			Thrombosis / embolism		
Dysfunction of the nervous system			Haemophilia		
Recent haemorrhage or swelling			Abdominal complaint		
Recent operation / fracture / sprain			Skin disorder		
Undiagnosed / acute pain			Osteoporosis		
Allergies, especially nuts			Migraines		
Raised temperature or fever			Athletes foot / verrucae		
Any blood related disorder					

	Yes	No
Serious illness, e.g. cancer*, multiple sclerosis		
Do you have any electronic implants, e.g. pacemaker?		
Do you have any dental braces, bridges or fillings?		
Are you currently under GP / hospital care?		

If you have answered YES to any of the above please give additional information here and advise your Therapist, prior to the start of your treatment. Please also note that Clarice House is not a medical centre and you are advised to visit your GP and contact us prior to your visit if you have any concerns regarding your health.

______

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***Cancer:** If you have ticked yes, please phone Beauty Reception at least two weeks prior to your visit or upon receipt of this form. Thank you.

Current medical treatment:

Current medication:

FEMALE CLIENTS

Pregnancy can seriously effect the treatments you have with us. We will have to adapt your treatments accordingly based on the stage of your pregnancy. Please advise -

Is it possible that you may be pregnant? Yes ☐ No ☐

If you think you may be pregnant, are you ☐ 4 weeks or less ☐ 12 weeks or less ☐ Over 12 weeks

If you have ticked either 12 weeks or less or 4 weeks or less and will be under 12 weeks pregnant at the time of your visit, please phone Beauty Reception prior to your visit or upon reciept of this form.

Are you currently menstruating? Yes ☐ No ☐

Are you breastfeeding? Yes ☐ No ☐

GENERAL HEALTH

On a scale of 1-10 (1 being the poorest) please rate:

Your general immunity/health ☐ Your energy levels ☐

Your sleep patterns? ☐ Your stress levels ☐

SKINCARE ROUTINE

Do you use products containing retinal A or AHA's (Alpha Hydroxy Acid)? Yes ☐ No ☐

What current routine do you have for your:

Face: Body:

LIFESTYLE

Are you on any special diet?:

Number of glasses of water consumed daily:

Do you drink tea or coffee? If so, how many cups?:

Do you drink alcohol? If so, approximately how much in a week?:

Do you smoke? If so, approximately how many a day?:

Type of exercise undertaken (and how frequently):

Do you relax regularly, if so how?:

Which holistic therapies have you tried in the past?:

Are you currently having any forms of treatment (includes chiropractic, osteopathy, homoeopathy, acupuncture, etc.)? Yes ☐ No ☐

IT IS NOT ADVISABLE TO HAVE AN AROMATHERAPY TREATMENT :

On the same day as other alternative therapies, eg. chiropractic, osteopathy, homoeopathy, acupuncture

Within 24hrs of innoculation

Within 24hrs of sunbed treatment

If you are or have suffered from epilepsy

If you are pregnant

Please advise prior to treatment if any of the above apply

CLIENT DECLARATION

I declare that the information I have given is correct, and as far as I am aware I can undertake treatment without any adverse effects. I have been advised about contra-indications and I am willing to proceed with the treatment.

Client's signature: Date: