

# Consultation Form

Date: .....

Patient No. ....

Surname: ..... Forename: ..... DOB: ..... Age: .....

Address: .....  
.....  
..... Home Tel: .....  
Work Tel: .....  
Mobile: .....

Sex: ..... Marital Status: ..... Children: .....

Email Address: ..... Ages: .....

Occupation: .....

Doctors Name: ..... Tel: .....

Doctors Address: .....  
.....

**Have you had or are you suffering from Cancer? Yes/No**

**Do you have allergies to?**

Nuts/Oils Yes/No  
Hayfever Yes/No  
Sinusitis Yes/No  
Eczema Yes/No  
Psoriasis Yes/No  
Any other Known Yes/No

**Are you?**

Diabetic Yes/No  
Epileptic Yes/No  
Are you wearing  
Contact Lenses Yes/No

**Are you/could you be pregnant? Yes/No**

**Date of LMP: .....**

**Do you suffer from/or have any of the following?**

Heart Problems Yes/No  
High Blood Pressure Yes/No  
Varicose Veins Yes/No  
Multiple Sclerosis Yes/No  
Arthritis Yes/No  
Rheumatism Yes/No  
Broken Bones/Strains Yes/No  
Recent Scar Tissue Yes/No  
Menstruation Yes/No  
Birth Pill Yes/No  
PMT Yes/No  
Menopausal Yes/No  
Anxiety Yes/No

Kidney Yes/No  
Indigestion Yes/No  
Gallstones Yes/No  
Constipation Yes/No  
Diarrhoea Yes/No  
Asthma Yes/No  
Eye Problems Yes/No  
Ear Problems Yes/No  
Migraine Yes/No  
Headaches Yes/No  
Insomnia Yes/No  
Nervous Stress Yes/No  
Depression Yes/No

**Spinal**  
Posture Yes/No  
Shoulders Yes/No  
Back Yes/No  
Neck Yes/No  
Lumbar Yes/No

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Recent Operations? .....

Do you have any other medical condition/illness?

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Are you on any medication?

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Are you intending to sunbathe or use a sunbed within the next 24 hours? Yes/No

Do you? .....

Take Supplements Yes/No .....

Smoke Yes/No How many per day? .....

Drink alcohol Yes/No Units per week? .....

Approx how much fluid do you take each day? .....

Exercise Yes/No Type: .....

How much training per week? .....

Is there any other health condition, which you think would affect you having therapy?

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Some Clients may have the following symptoms for up to 48 hours after a therapy. Headaches, Emotionally Upset, Lethargic, Energized, Flu Like, Achy. This is a result of your mind and body absorbing the essential oils.

**Disclaimer**

I have answered the questions truthfully. I understand the therapist has gone through this consultation with me, to identify if there are any contra-indications that would affect me having a treatment. I also understand that this is to safeguard me as well as the therapist. I therefore do not hold the therapist KAMILA GLASEK liable.

Client Signature: .....

Client To Print Name: .....

Date: .....