CLIENT CONSULTATION

PRIVATE AND CONFIDENTIAL

The following information is required for the purpose of understanding elements of your health and wellbeing to establish the correct treatment plan and approach. It may be necessary to consult with medical practitioners before any treatment can be given. All information provided will be treated in the strictest confidence and conforms with all GDPR compliance regulations.

Date of Consultation:___________________ Therapist Name:____________________

ABOUT YOU

Name	
Address	
Date of Birth	
Gender	
Home Address	
Telephone No	
Email Address	
Do you give consent for information to be stored which is relevant to your treatment? All information is held in the strictest confidence	

YOUR HEALTH

List any current medical conditions	
List any historical conditions	
List any previous operations	
Family history	
How would you describe your current health?	
Do you have any allergies?	
Do you take any medication?	
Female Only Questions	
Are you or could you be pregnant?	
If yes please state number of weeks	
Are you currently breastfeeding?	
Are your periods regular? Please describe any issues with your menstruation cycle	

YOUR PHYSICAL WELLBEING

Do you suffer from any of the following?

Muscular/Skeletal Issues	Neck Back Rheumatism Arthritis Aches and Pains Stiff Joints Headaches
Digestive Issues	Constipation Diarrhoea Bloating Liver/Gall Bladder Stomach – Heartburn/Indigestion Diabetes
Circulation Issues	Heart Blood Pressure Fluid Retention Tired Legs Varicose Veins Cellulite Kidneys Cystitis Cold Hands and Feet
Gynaecological Issues	Irregular Periods PMT Menopause HRT Contraceptive Medication Other
Nervous System	Migraine Tension Headaches Stress Depression Anxiety Epilepsy
Immune System	Low Immune System Cough and Colds Chest Infections Other Infections
Have you ever been diagnosed with Cancer? If yes please provide more details	
Any other concerns or issues with your physical wellbeing?	

YOUR LIFESTYLE & MENTAL WELLBEING

Do you have concerns with any of the following:

Mental Wellbeing	Depression Anxiety Panic Attacks Insomnia		
Overall Stress Level	Low	Manageable	High
Work Stress Level	Low	Manageable	High
Ability to Relax	Good	Average	Poor
Sleep Pattern	Good 8-9 hours	Average 6-7 hours	Poor < 6 hours
Diet	Strict Diet	Healthy Balance	Poor Diet
Do you follow any specific diet?	Vegetarian Vegan Slimming World Cambridge Plan Weight Watchers Atkins Keto 5:2 Low-Carb Other – please state:		
Alcohol Intake	None	Occasional	Daily
Do you smoke?	None	Occasional	Daily
Exercise Level	Daily	Occasional	None
General Skin Conditions	Acne Eczema Dermatitis Psoriasis Other – please state:		
Is there any other information that your therapist should be aware of?			

YOUR CONSENT

We pride ourselves at Feather Wellness and Beauty on treating our clients information in the strictest of confidence. All information gathered is for the purpose of evaluating your overall health and wellbeing so that the correct treatment can be recommended, and to protect you should a treatment not be suitable.

By signing this form you declare that all information is correct to the best of your knowledge and you give consent for treatment to be given. You are aware of the contra-indications and are happy to proceed with treatment.

Name:	
Signature:	
Therapist Name:	
Therapist Signature:	
Date:	