Date: Name: Address: Phone / E-mail: D.O.B:

Please complete the following questions. Please be assured that the information that you give is completely confidential and held in accordance with Data Protection Legislation. All information gathered is used to inform and safeguard the therapy you receive.

Current Health Issues:

Aspirations for the treatment? / What outcome are you seeking for this visit?

Occupation:

Lifestyle (exercise, activities, diet, vitamins, etc.):

Other forms of Holistic Healing / Bodywork: Are you under stress? Rate 1-5 (5 high stress) At work? At home? Do you have headaches? Yes / No How often? Relieving factors?

Do you sleep well? Yes / No

Problems falling asleep? Once asleep, waking? How often? Do you wake feeling rested?

Medical History

Are you currently under medical supervision yes / no Details: Are you currently on any medication? yes / no If yes, are there any side effects I need to be aware of? Are you currently pregnant? yes / no

Do you have menstrual / menopausal problems? Explain: yes / no Are you living with any of the following conditions?

Epilepsy / Diabetes / Drug or Alcohol Dependency / Allergies / Low Blood Pressure

Do you have any joint problems? (Arthritis, etc.) Where? yes / no How is your spine? (neck / mid back / low back)

Are you aware of any other condition that may affect your treatment? yes / no If yes, please comment:

To the best of my knowledge the above information is correct and I am okay with being gently touched appropriately by the practioner during the treatment.

Signed: Dated: