Initial Consultation Record

- *In order to make your treatment as effective and safe as possible, please complete the form below prior to your treatment. All information collated is STRICTLY CONFIDENTIAL and will be preserved as part of your client record*

Please ensure you complete the consultation form as thoroughly as you can, noting any surgery or illnesses you may have had in the last 2 years. Remember to include details of any medication you may be on for any conditions, allergies or illnesses which may be impacted by the treatment.

Name____ DOB_____________

Address____

____

________________________________ Postcode____________

Tel: (Pref. Mobile) _____________________________________

E-mail____

History of medical conditions (Past, Present) Some conditions may require treatment to be adapted, delayed or completely prevent it.

Do you suffer from any of the following?

Condition	Y/N	Details
Conjunctivitis, glaucoma, impetigo Lash mites, Stye, Scabies, Blepharitis		
Skin conditions such as Dermatitis, psoriasis, eczema		
Recent surgery, cuts, bruises, inflammation or swelling		
Long term conditions such as Diabetes, Cancer, HIV, Asthma		
Do you have any allergies?		
Any other details or information your therapist should be aware of		

I have not withheld any information regarding my health and the information I have provided is true to the best of my knowledge. I understand - as my body adjusts to the treatment provided - I may develop some minor reactions to it. I have been informed of contra indications and whilst all due care will be taken by my therapist, I am aware that my involvement in the treatment is of my own choice

Signature________________________ Date__________