Clarity Treatments
for health, wellbeing & recovery

Consultation Form

Todays' date:_____

Name:_____ Date of birth:_____ Age:_____

Address:_____

_____ Occupation:_____

GP contact details:_____

Post code:_____ _____

Telephone number:_____ Mobile number:_____

E-mail address:_____ How referred:_____

Medical History: (please give dates)

Surgery/operations/procedures:

Fractures:

Accidents:

Current medication, (prescription and over the counter) and alternative supplements:

Have you been referred for further investigation, out-patient therapy, physiotherapy or other therapy by your GP/Consultant? If so what and when?

Health problems

Do you have, or have you ever had any of the following conditions? (Please tick all that apply.)

- ❑ circulatory disorder
- ❑ respiratory disorder
- ❑ heart condition
- ❑ high/low blood pressure
- ❑ thrombosis
- ❑ dizzyness
- ❑ blackouts
- ❑ dental complaints
- ❑ varicose veins
- ❑ epilepsy
- ❑ diabetes
- ❑ abdominal complaint
- ❑ skin disorder
- ❑ bowel complaint
- ❑ bladder complaint
- ❑ visual disturbance
- ❑ allergies
- ❑ arthritis
- ❑ osteoporosis /osteopenia
- ❑ nervous system disorder (MS, stroke)
- ❑ headaches /migraines
- ❑ tinnitus (ringing in the ears)
- ❑ eating disorder
- ❑ a potentially terminal condition

General

Height:_____ Weight:_____ Special Diet:_____

Smoker? Yes No If yes how many per day_____

How much water do you drink?_____ /day Alcohol consumption light / moderate / heavy

Sport/exercise/relaxation_____

How would you describe your stress levels? high / moderate / low

Your Reason for Treatment

What is your primary complaint?(When did it start? How does it affect you?)_____

_____

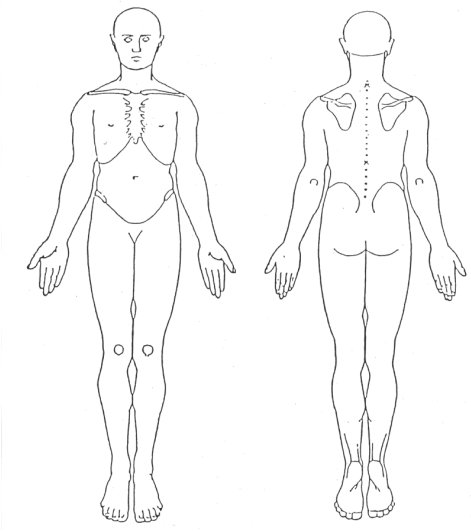
Have you had any X-rays, MRI or tests? What was the result?_____

_____

What is the level of discomfort? (0 being the least) 0 1 2 3 4 5 6 7 8 9 10

Do you have any additional reasons for seeking treatment?_____

_____



Please shade on the diagram the areas you feel your pain and discomfort. Place a (x) for areas of numbness or tingling.

FEMALES

How many pregnancies have you had? How many children do you have?

Did you have any difficulty with delivery. If yes what? yes no

Have you had a caesarean section? yes no

If you are still having periods are they regular? yes no Do you consider yourself?

❑ Perimenopausal ❑ Menopausal ❑ Postmenopaulsal

Do you have any symptoms from the above that bother you?

DENTAL AND JAW ISSUES

Please tell us about any dental and jaw issues which have resulted in surgery, braces, bridges, implants, crowns, difficult extractions and dentures.

❑ Intraoral MFR can be performed to relieve tight jaw and face muscles. Please tick this box if you agree to this treatment

CONSENT FOR TREATMENT AND PHYSICAL EXAMINATION

Thank you for providing me with the relevant information on your medical status and your personal details.

A treatment consists of a discussion concerning general medical information and specific information regarding your present complaint, after which a physical examination will be carried out. This will include an in-depth assessment of your presenting complaint as well as any other relevant examination procedures. You will be required to change down to your underwear, or if you prefer shorts and a bra top. During treatment you will be draped with sheets or towels.

On subsequent treatments, further assessments will be carried out to establish changes to your posture and function and presenting complaint.

Children will not be treated without a parental or guardian's permission.

❑ Please tick this box if you do not wish me to leave a voicemail or message on your telephone number.

All patient information, medical history, personal details and treatment plans are stored in compliance with the Data Protection Act.

Payment
Payment is accepted by cash, cheque or bank transfer. Account: Alison Wagner. Bank: Santander
Sort Code: 09-01-29 Account Number: 28249928

I understand that charges will apply if I give less than 24 hours notice of any cancellation. I understand that I must inform my therapist if my medical circumstances change at any time.

Signature of client: Date:

Signature of therapist: Date: