The following information will be used to plan safe and effective treatment sessions for you. Please answer the questions to the best of your knowledge. Thank you.

CLIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel. No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E-MAIL ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON FOR SEEKING THERAPY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHEN DID THIS CONDITION START?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IS THERE ANYTHING THAT MAKES YOUR CONDITION WORSE OR BETTER?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_IF YES, PLEASE EXPLAIN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU RECEIVED TREATMENT FOR THIS CONDITION?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU ATTENDING YOUR DOCTOR? \_\_\_\_\_\_CURRENT MEDICATION?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

G.P NAME AND PRACTICE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE CHILDREN?\_\_\_\_\_\_\_ARE YOU PREGNANT?\_\_\_\_\_\_\_\_\_\_\_ NR. OF WEEKS\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE SELECT ANY OF THESE CONDITIONS THAT APPLY TO YOU**

* ALLERGIES
* ANXIETY
* ARTHRITIS
* ASTHMA
* AUTISM ESPECTRUM
* BACK /NECK PAIN
* JOINTS ACHES AND PAINS
* BLOOD CLOTS
* VARICOSE VEINS
* THROMBOSIS
* BLOOD PRESSURE H/L
* DIABETES
* BREATHING PROBLEMS
* BROKEN BONES
* CANCER
* CHEST PAIN
* BRAIN DAMAGE
* DISLEXIA/DISPRAXIA
* CONSTIPATION
* BLOATING
* LIVER/GALLBLADDER
* STOMACH
* DIGESTIVE PROBLEMS
* DENTAL WORK
* DEPRESSION
* DIFFICULTY SWALLOWING
* DIZZINESS
* EAR PROBLEMS/TINNITUS
* EPILEPSY
* FIBROMYALGIA
* NEUROLOGICAL CONDITIONS
* NUMBNESS
* PINS AND NEEDLES
* HEADACHES/MIGRAINES
* HEART PROBLEMS
* IMPLANTS/STENTS
* OPERATIONS
* SKIN PROBLEMS
* SLEEP PROBLEMS
* STRESS
* IRREGULAR PERIODS
* MENOPAUSE
* PMS
* MULTIPLE SCLEROSIS
* PRONE TO INFECTIONS
* SINUSITIS
* URINARY PROBLEMS
* CHRONIC TIREDNESS
* BEREAVEMENT
* EMOTIONAL STRESS

ANY OTHER CONDITION NOT LISTED THAT YOU THINK I SHOULD KNOW\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| How is your general feeling? From 1 being low to 10 being the highest | 1. Wellbeing -
2. Energy -
3. Diet -
4. Sleep -
5. Fatigue –
6. Depression –
7. Anxiety –
 |

Was there anything abnormal about your birth E.g. Forceps?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking prescribed medication? If yes please list and state condition being treated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise routine, what you do in an average week\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience stress in your work, family or other aspects of your life? YES/NO.

 If Yes, how do you think it affects your health\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you like to achieve on a session ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

****Area/s of specific aches and pains

**PATIENT RELEASE AND CONSENT TO TREATMENT**

I understand that this treatment may involve a combination of techniques, including physical assessment, Massage, remedial exercise, soft tissue techniques, Stretching, heat and cold applications, Physiotherapy exercises advise, CranioSacral Therapy –SomatoEmotional Release, Aquatic therapies, or other techniques such as Ancestral healing, coaching or mindfulness, either singly or in various combinations.

I understand that some techniques may be uncomfortable, (However the therapist will do their best to avoid this, and will respond to your feedback).

I understand that all treatments will be explained to me by Susana from Sanasutouch, and I give my consent to the treatment provided.

I realise that the particular outcomes of these treatments individually and jointly, cannot be predicted with certainty and no guarantee is made regarding any particular result or outcome.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_