**Date:** Click here to enter a date.

|  |  |
| --- | --- |
| **Name:** |  |
| **Address:**  **Post Code** |  |
| **Profession:** |  |
| **Telephone No/s** |  |
| **Email** |  |

**PERSONAL DETAILS**

**Age group:** Under 20  20-30  30-40  40-50  50-60  60+

**Lifestyle:** Active  Sedentary  **Last visit to the doctor:**

**GP address:**

**Number of children (if applicable):**  **Date of last period (if applicable):**

**CONTRAINDICATIONS REQUIRING MEDICAL PERMISSION – in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment.** (Select if/where appropriate):

Pregnancy

Cardio vascular conditions (thrombosis, phlebitis,

Hypertension, hypotension, heart conditions

Haemophilia

Any condition already being treated by a GP or

Another complimentary therapist

Medical oedema

Osteoporosis

Arthritis

Nervous/Psychotic conditions

Epilepsy

Recent operations

Diabetes

Asthma

Any dysfunction of the nervous system (e.g.

Multiple sclerosis, Parkinson’s disease,

Motor neurone disease)

Bell’s palsy

Trapped/Pinched nerve (sciatica)

Inflamed nerve

Cancer

Postural deformities

Cervical spondylitis

Spastic conditions

Kidney infections

Whiplash

Slipped disc

Undiagnosed pain

When taking prescribed medication

Acute rheumatism

**CONTRAINDICATIONS THAT RESTRICT TREATMENT** (Select if/where appropriate)

Fever

Contagious or infection diseases

Under the influence of recreational drugs or alcohol

DIarrhoeea and vomiting

Skin diseases

Undiagnosed lumps and bumps

Localised swelling

Inflammation

Varicose veins

Pregnancy (abdomen)

Cuts

Bruises

Abrasions

Scar tissue (2 yrs for major operation, 6 months small scar)

Sunburn

Hormonal implants

Menstruation (abdomen -first few days)

Haemotoma

Hernia

Recent fractures

Gastric ulcer

After a heavy meal

Conditions affecting the neck

**WRITTEN PERMISSION REQUIRED BY** (Select if/where appropriate):

GP/Specialist Informed consent

Either of which should be attached to the treatment form.

**PERSONAL INFORMATION** (Select if/where appropriate):

**Muscular/Skeletal problems:** Back  Aches/Pains  Stiff joints  Headaches

**Digestive Problems:** Constipation  Bloating Liver/Gall bladder  Stomach

**Circulation:** Heart  Blood pressure  Fluid retention  Tired legs  Varicose veins

Cellulite  Kidney problems  Cold hands and feet

**Gynaecological:** Irregular periods  P.M.T  Menopause  H.R.T  Pill  Coil  Other

**Nervous system:** Migraine  Tension  Stress  Depression

**Immune system:** Prone to infections  Sore throats  Colds  Chest  Sinuses

**Regular antibiotic/medication taken?** Yes  No  If yes, which ones

**Herbal remedies taken?** Yes  No  If yes, which ones

**Ability to relax:** Good Moderate  Poor

**Sleep patterns:** Good  Moderate  Poor

**Do you see natural daylight in your workplace?** Yes  No

**Do you work at a computer?** Yes  No  If yes, how many hours per day

**Do you eat regular meals?** Yes  No

**Do you eat in a hurry?** Yes  No

**Do you exercise?** Yes  No  If yes, which ones

**Do you take any food/vitamin supplements?** Yes  No  If yes, which ones

**How many units of these drinks do you consume per day?**

Tea: Coffee: Fruit juice: Water: Soft drinks: Others:

**Do you suffer from allergies?** Yes  No

**Do you suffer from eating disorders?** Bingeing? Yes  No  Overeating? Yes  No  Undereating? Yes  No

**Do you smoke?** Yes  No  If yes, how many per day?

**Do you drink alcohol?** Yes  No  If yes, how many units per day?

**Do you exercise?** None Occasional Irregular Regular Types

**What is your skin type?** Dry Oily Combination Mature Young Normal

**Do you suffer/have you suffered from:** Dermatitis Acne Eczema PsoriasisAllergies Hayfever Asthma Skin Cancer

**Stress level: 1-10** (10 being the highest)

At work: At home:

**Sign Form Here:**

**Email** your finished form to [pauline@paulineblackwood.co.uk](mailto:pauline@paulineblackwood.co.uk)

Your appointment is one step closer

**Thank you for choosing Pendulum Massage**