Karen Hilbrown Beauty Therapy

Holistic Services Consultation Form

TO BE COMPLETED BY THE CLIENT BEFORE EACH SESSION:

The following information is required for your safety, and to benefit your health and welfare. The following details will be treated with the strictest confidence.

First Name:……

Last Name:……

Date of Birth:……

Address: ……

Email:…… Telephone:…….…… Mobile:…….....

Occupation:……

Referred By (if applicable) .....

Marital Status .....

Number & Age of Children or Dependants .....

Doctor's name (your doctor will not be contacted without your written permission)

.....

Doctor's Address .....

Doctor's Telephone: .....

Do you suffer, or have you ever suffered, from any of the following: (If so then please give full details)

Diabetes

Kidney problems

Epilepsy

Photosensitivity

Surgery or injury to back or joints

Sensitive skin

Allergic skin rashes

Allergies

Varicose Veins

Deep vein thrombosis

Heart disease

High or low blood pressure

Cancer

Stroke

Asthma

Migraines

Are you currently taking any prescribed or self-prescribed drugs or remedies? (If so then please give full details)

In the next 12 hours, will any of the following apply: (If so then please give full details)

Driving or operating heavy machinery

Drinking alcohol

Using a sunbed or exposing your skin to ultraviolet light

Women only: Is there any possibility you might be pregnant?

Are you currently menstruating?

I confirm that the information given above is correct and complete. I will inform my therapist before receiving treatment if any of the information above changes at any time during my treatment.

Signed:

Date: