Client form

Name	
Address	
Tel No Home	Mobile
DOB	Occupation
GP's Name and Address	

Past Medical History

Do you suffer from…	No	Yes	Please give details wherever 'Yes' has been ticked
Heart/Circulatory/High BP/Low BP			
Varicose Veins			
Thrombosis/DVT/PE			
Chest condition/Asthma			
Allergies			
Epilepsy			
Diabetes			
Neurological condition			
Liver/Kidney condition			
Cancer/serious illness			
Rheumatoid Arthritis			
Digestive condition/IBS			
Urinary/Gynaecological condition			
Operations			
Migraines/Headaches			
Fractures			
Skin condition			
Stress/Depression			
Mental illness			
Addictions			
Pregnant?			

General Health
Medication and use
Hypnotherapy experience
Massage experience

Disclaimer

The therapy has been explained to me in full and I, the undersigned, am giving consent for this combined hypnotherapy treatment and therapeutic massage. The information I have provided is complete and accurate. I understand that I can stop the treatment at anytime by just opening my eyes and requesting the treatment to stop.

Client   Name of Practitioner

Date

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