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|  |  |  |
| NAME: | DATE: | TREATMENT NO: |
| ADDRESS | TELEPHONE (INCL CODE): | THERAPIST’S NAME |
| POSTCODE | EMAIL: |

**WHAT TREATMENT IS BEING GIVEN TODAY (i.e., massage, counselling reflexology) :**

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| **DETAILS OF ANY CONTRA-INDICATIONS:** |

**RECENT MEDICAL HEALTH SINCE LAST TREATMENT**

|  |  |
| --- | --- |
| OPERATIONS/TRAUMA |  |
| ILLNESSES/DISEASES |  |
| AREA OF PAIN |  |
| ALLERGIES/SKIN PROBLEM |  |
| CHANGES IN MEDICATION |  |
| BOWEL FUNCTION |  |
| ENERGY LEVELS (1 = LOW - 10 = HIGH) |  |
| STRESS LEVELS (1 = LOW – 10 = HIGH) |  |
| **ANY COMMENTS REGARDING LAST TREATMENT (IE CONTRA ACTIONS):** | |
| **Please write down one or two concerns or problems the client would like most help with**  Client’s concern or Problem 1  Smiling Face with No Fill. Neutral Face with No Fill Sad Face with No Fill  1 5 10  Not bothering me at all. Bothers me greatly | |
| Client’s concern or Problem 2  . Smiling Face with No Fill Neutral Face with No Fill Sad Face with No Fill  1 5 10  Not bothering me at all. Bothers me greatly | |
| . **The benefits of this treatment may not be felt immediately, but rate 1-10 how you are feeling at present**  Smiling Face with No Fill Neutral Face with No Fill Sad Face with No Fill  1 5 10  As good as it could be. As bad as it could be  What were the most important aspects of this session? | |
| **DATE OF NEXT TREATMENT:** | |
| **Please ask for an email address if they wish to be added to our newsletter mailing list. This email list is not shared with any third party** | |
| **NB: At last treatment please remind the client their details can be removed from our database upon written request in line with GDPR2018 requirements, otherwise details are automatically deleted after 3 years.** | |