The Wendy House of Beauty Consultation Form

Thank you for taking the time to complete this form

FULL NAME : _____

DATE OF BIRTH : _____

CONTACT NUMBER : _____

EMAIL ADDRESS : _____

ALLERGIES BOTH MEDICAL & NON MEDICAL : _____

_____

NAME & ADDRESS OF GP : _____

_____

PLEASE STATE IF YOU HAVE EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING :

- HEART DISEASE
- HISTORY OF BLOOD CLOTS
- EVER BEEN DIAGNOSED WITH CANCER
- ANY HISTORY OF TRAUMA RELATED INJURIES eg CAR ACCIDENT, NECK INJURIES
- ANY NUMBNESS TO LIMBS
- ANY PREVIOUS SURGERY
- DIABETES
- HIGH BLOOD PRESSURE
- LOW BLOOD PRESSURE
- SKIN RELATED CONDITIONS eg PSORIASIS, ECZEMA, HIDRADENTITIS SUPPURATIVE (HS)

- FIBROMYALGIA
- ANY INFECTIOUS DISEASES eg HEPATITIS, STDs
- RECENT INJURIES OR ILLNESS
- POSSIBLY PREGNANT

ANY OTHER HEALTH ISSUES? _____

_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS OR SUPPLEMENTS, PRESCRIBED OR OVER-THE-COUNTER? _____

OCCUPATION / EDUCATION : _____

GENERAL INTERESTS ie SPORTS ETC : _____

_____

I ACKNOWLEDGE THAT ALL THE INFORMATION ON THIS CONSULTATION FORM IS ACCURATE & CORRECT TO THE BEST OF MY KNOWLEDGE : _____

I ACCEPT FULL & COMPLETE RESPONSIBILITY FOR MY OWN EMOTIONAL & PHYSICAL WELLBEING BOTH DURING & AFTER THE TREATMENT : _____

I AGREE TO INFORM THE THERAPIST OF ANY CHANGES TO MY CIRCUMSTANCES DURING ANY SUBSEQUENT TREATMENTS : _____

I REALISE ANY ADVICE GIVEN TO ME TO CARRY OUT BETWEEN TREATMENTS IS IMPORTANT AND I AGREE TO MAKE EVERY EFFORT TO CARRY THIS OUT : _____

I MAY TAKE PHOTOS FOR SOCIAL MEDIA PURPOSES - ARE YOU HAPPY TO BE INCLUDED? _____

SIGNED BY : _____

DATE : _____

Thank you for completing this form
Wendy x