Consultation Card

Name ______________________________

Age ______________________________

Address ______________________________

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Postcode ______________________________

Email ______________ **Phone** ______________

Please tick the box if you suffer from or have any of the following:

- ☐ Allergies
- ☐ Asthma
- ☐ Diabetes
- ☐ Pregnancy or trying to get pregnant
- ☐ Eczema / Psoriasis
- ☐ Skin disorders
- ☐ Cold Sores / Verrucas
- ☐ Thrombosis or Embolism
- ☐ Severe Varicose Veins
- ☐ Nervous system disorder
- ☐ Recent dental surgery
- ☐ Metal pins or plates
- ☐ Arthritis
- ☐ Cancer
- ☐ Epilepsy
- ☐ High or low blood pressure
- ☐ Hypertension
- ☐ Headaches or migraines
- ☐ Infections or irritations
- ☐ Recent operations
- ☐ Prescription medicines
- ☐ Pacemaker

Is there any other illness that your therapist should know about?

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I declare that all the information I have given is correct.

Disclaimer I have been informed about the treatment contra-indications risks and I am willing to proceed with the treatment at my own risk.

Signed ______________ **Date** ______________