**CONSULTATION FORM**

Please note this form must be kept for a minimum of 7 years for insurance purposes (all sections with a **\*** need to be completed)

**\***Client name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Date of birth \_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Postcode \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\***Contact number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What communications would you like to receive from us?**

Appointment Reminders □

Promotions and Offers □

Newsletters □

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □

**How would you like to receive them?**

Phone □

Mobile SMS □

Email  □

Post □

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □

**\*Doctor’s name and address**

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**\*** **Previous treatments and reason for treatment**

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**\*MEDICAL HISTORY**

If any are marked yes, please go into more detail in the space under the condition.

Prone to keloid scarring yes/no

Hormone imbalance yes/no

Stroke yes/no

Claustrophobia yes/no

Hepatitis yes/no

Metal plates/pins/piercings yes/no

Recent scar tissue/surgery yes/no

Respiratory problems yes/no

Allergies yes/no

High/low blood pressure yes/no

Operations within 6 months yes/no

Heart conditions/pacemaker yes /no

Severe circulatory disorders/DVT yes /no

Diabetes yes/no

Skin disorders yes/no

Kidney problems yes/no

Swelling/oedema yes/no

Haemophilia yes/no

Cancer yes/no

Limitation of body movement/arthritis yes/no

Are you pregnant yes/no

Epilepsy yes/no

**\*Any other medical conditions/ailments yes/no**

Please specify

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**\*Medication/treatments / additional information**

Retinol or Roaccutane yes/no

Products containing fruit acids yes/no

Microdermabrasion yes/no

Laser/IPL yes/no

Steroids yes/no

Other medication yes/no

Ultra violet exposure yes/no

Any other medications yes/no

\*Please specify

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**\***Declaration I declare that the above information I have given concerning my health is correct

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

**\*COVID-19 Health Assessment Questionnaire**

For the foreseeable future a health assessment questionnaire must be completed and sent in, together with your new consultation card if this is your first ever appointment, or sent in on its own ahead of each appointment stored and documented by your therapist on each appointment update thereafter.

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| Date Completed | Signature |
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**\*Updates/Changes**

Please advise us of any personal or medical changes applicable to this consultation form since your last treatment with us? If none, state NONE with your signature and date.

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| Date | Amendment of details | Signature |
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**Please NOTE** remember to attach all relevant patch test forms and parental consent forms where applicable