AILEEN PALMER HOLISTIC THERAPY

REFLEXOLOGY ~ INDIAN HEAD MASSAGE
REIKI ~ ACCESS BARS ~ EAR CANDLING

CONSULTATION FORM

Name		**Email**	
Address			
Tel No.		**D.O.B**	
Emergency Contact Details			

Medical History

Do you have or are you prone to any of the following conditions?

Any Condition being treated by GP or other Complimentary Therapist			
Asthma		Motor Neurone Disease (MND)	
Diabetes		Muscular Sclerosis (MS)	
Epilepsy		Parkinson's Disease	
Fever		Cancer	
Heart Condition		Osteoporosis	
Circulatory Issues – Thrombosis or Phlebitis		Pregnancy	
Cold Hands or Feet		Nervous / Psychotic Conditions	
Blood Pressure -High or Low		Recent Operations	
Varicose or Inflamed Vein		Recent Fracture	
Digestive Issues		Scar Tissue	
Vomiting or Diarrhoea		Skin Issues-Dermatitis/Eczema/Psoriasis	
Constipation, Bloating or Fluid Retention		Abrasions or Broken Skin	
Allergies		Kidney or Bladder Infections	
Joint disorders (e.g. Arthritis/rheumatism)		Muscular Aches (tired legs)	
Trapped/Pinched/Inflamed Nerve		Inflammation, Swelling or Bruising	
Sciatica or Slipped Disc		Contagious or Infectious Conditions	
Sore Throats, Chest Infections or Coughs		Under the influence of alcohol/drugs	
Headaches / Migraines		Undiagnosed Lumps or Pain	
Stress, Anxiety or Tension		PMT/Irregular Cycle/ Menopause	
Depression		Contraception	
Other			

If you have answered yes to any of the above, please give details:

_____

Current medication: _____

Doctor's Details: _____ **Tel:** _____

Aileen Palmer Holistic Therapy
Unit 6, Portmarnock Town Centre, Strand Road, Portmarnock, Co Dublin
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info@aileenpalmerholistictherapy.ie
087 9256 333

Lifestyle

How frequently do you exercise: _____ What type: _____

How many hours of fresh air per day: _____ Do you have a healthy diet: _____

How many portions do you eat (per day) of the following?

Fresh fruit		**Fresh vegetables**	
Protein		**Dairy produce**	
Sweet things		**Added salt**	
Added sugar		**Water**	
Tea		**Coffee**	
Alcohol (per week)		**Cigarettes**	

Is your sleep very good, good, fair, or poor: _____

What do you do to relax (yoga, meditation etc.): _____

Do you have other hobbies or interests: _____

Is your work active or sedentary: _____

Do you work at a computer: _____ How many hours per day: _____

On a scale of 1 to 10, (1 being lowest) how do you rate your stress levels?

Work: _____ At home: _____

Due to data protection regulations your consent is required for me to collect and store your information and to contact you in relation to future treatments. I will only collect information relevant to your treatment and I will not share your data with any third party. You are entitled to access your information if/when required with written notice.

I give consent to collect and store my data **Yes or No**

I wish to be contacted/reminded about future treatments **Yes or No**

Client's Signature: _____

Therapist's Signature: _____

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