HM Health & Well-being – Client Consultation Form

Mr/Mrs/Miss/Ms/other:			
Surname:		**First Name:**	
Date of Birth:		**M/F:**	
Address:			
Contact Numbers	**M:**	**H:**	**W:**
Email Address:			
	GP DETAILS		
Name:		**Contact Number:**	
Surgery:			
Address:			

Do any of the following apply to you (pick tick):

Infection skin disorders		Heart conditions/ circulatory disorders		Diabetes	
Hic fever, temperature or illness		Recent haemorrhage or surgery		Migraine	
Asthma		Eczema/Psoriasis		Bruising	
Recent scar tissue (<6 months old)		Arthritis		Pregnancy	
Allergies		Epilepsy		High or low blood pressure	
History of embolism/ thrombosis		Cancer		Recent sprain	
Recent broken bones/ fractures		Hip problems		Dysfunction of nervous system	
Back problems		Depression			
Do you have any other conditions not mentioned above?					
What prescription medications are you taking?					
Have you had Cupping Therapy before?			**If yes, did you have any problems?**		

CLIENT DECLARATION: *I confirm that to the best of my knowledge the information stated above is accurate and I have not withheld any information that may be relevant to my treatment. I agree that I am happy to receive the treatment outlined to me. I further understand that treatment may leave marks and/or a feeling of tenderness which may last a number of days.*

Client Signed: ..... Date: .....

Therapist Signed: ..... Date: .....

These records shall be kept for at least 7 years following the last occasion on which treatment was given. In the case of treatment to minors, it is advised that the records should be kept for at least 7 years after they reach the age of majority (18).