

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Tel.:(h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_ E-mail \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Occupation: \_\_\_\_\_

Contact in case of Emergency: \_\_\_\_\_ Tel: \_\_\_\_\_

What brings you in today? \_\_\_\_\_

Therapy requested: \_\_\_ Tuning Fork Therapy \_\_\_ Lithotherapy \_\_\_ Energy Therapy \_\_\_ Chakra Balancing \_\_\_ Reflexology

**Please check any conditions that apply to you (past & present)**

<p align="center"><b>Head</b></p> <p>___ Sinus headaches          ___ Tension headaches          ___ Migraine headaches          ___ Vision problems          ___ Cataracts          ___ Ear aches          ___ Hearing problems          ___ Dizziness          ___ Other _____</p>	<p align="center"><b>Skin</b></p> <p>___ Allergies: type _____          ___ Rashes/Eruptions          ___ Warts          ___ Itching          ___ Bruise easily          ___ Cold sores          ___ Sensitive skin          ___ Other _____</p>	<p align="center"><b>Women</b></p> <p>___ Menstrual problems          ___ Menopausal problems          ___ Pregnant: due date _____          ___ Children: number _____          ___ Gynaecological surgery          ___ Other _____</p> <p align="center"><b>Men</b></p> <p>___ Prostate problems          ___ Hernia          ___ Other _____</p>
<p align="center"><b>Respiratory</b></p> <p>___ Chronic cough          ___ Shortness of breath          ___ Asthma          ___ Bronchitis          ___ Emphysema          ___ Allergies: type: _____          ___ Sinus problems          ___ Smoker          ___ Other _____</p>	<p align="center"><b>Cardiovascular</b></p> <p>___ High blood pressure          ___ Low blood pressure          ___ Shortness of breath          ___ Heart attack          ___ Stroke          ___ Chronic congestive heart failure          ___ Heart disease: type _____          ___ Poor circulation          ___ Phlebitis          ___ Varicose veins          ___ Anemia          ___ Pacemaker          ___ Other _____</p>	<p align="center"><b>Digestive</b></p> <p>___ Constipation          ___ Diarrhea          ___ Irritable Bowel Syndrome          ___ Diverticulitis          ___ Crohn's Disease          ___ Colitis          ___ Gallbladder          ___ Liver          ___ Gas/bloating          ___ Hyatus hernia          ___ Other _____</p>
<p align="center"><b>Other Health Care</b></p> <p>___ Massage Therapy          ___ Physiotherapy          ___ Chiropractic          ___ Psychotherapy          ___ Regular exercise          ___ Regular eating habits          ___ Meditation          ___ Yoga/Tai Chi          ___ Other _____</p>	<p align="center"><b>Other Conditions</b></p> <p>___ Kidney          ___ Bladder          ___ Arthritis: type _____          ___ Diabetes          ___ Cancer: type _____          ___ Epilepsy          ___ Osteoporosis          ___ Numbness/Tingling          ___ Pins/Wires/Joint replacement          ___ Other _____</p>	<p align="center"><b>Other Conditions Continued</b></p> <p>___ Thyroid problem          ___ Fatigue          ___ Fibromyalgia          ___ Depression          ___ Eating Disorder          ___ Unusual weight loss/gain          ___ Spinal disorder _____          ___ Foot problems _____          ___ Other _____</p>

Sleep Habits:(check one) \_\_\_ Always well \_\_\_ Sometimes well/Sometimes not \_\_\_ Mostly not enough \_\_\_ Never enough

How would you rate your stress level (1=low/10=high) \_\_\_\_\_ Last blood pressure rate: \_\_\_\_\_

Herbs/Vitamins/Minerals/Supplements: \_\_\_\_\_

Current Medication(s): \_\_\_\_\_

Surgeries: \_\_\_\_\_

Accidents/Injuries: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ Tel: \_\_\_\_\_

Date of your last visit: \_\_\_\_\_

*I acknowledge that the therapist cannot diagnose, nor prescribe, and that any suggestions offered are based on the therapist's studies and practice. Any suggestions offered are not intended to replace appropriate medical investigation and treatment. They are offered as guidelines for the client to design their own personal wellness programme.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_