Trinité Consultation and Consent Form

Date……

Forename (Pre nom)……

Surname (Nom)……..

Address ……

……..

Telephone……..e-mail ……

Date of Birth (née)……Occupation……..

Doctors name & Address……

……Telephone……..

Are you currently receiving medication or treatment from your GP or a specialist? YES/NO

If YES, please give details (including medicine & dose)……..

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Female Clients

Date of last period……...do you suspect you are pregnant? YES/NO

Medical History

Medical Conditions & Common Ailments	**Currently Suffer from**	**Have Suffered from**	**Family History of condition**
Abdominal & Digestive : Constipation, Diarrhoea, IBS, Candida, Gastric Ulcers, Hernias, Hepatitis, Colitis, Food Allergies/ Intolerances, Coeliac or Crohn's Disease			
Skin Allergies and Intolerances: Dermatitis, Eczema, Psoriasis, Sun Burn, Skin Diseases, Undiagnosed Lumps, Allergies ie to creams, plasters stings, nuts etc			
Cardio Vascular, Circulatory: Heart Conditions, Angina, Thrombosis, Pacemaker, Hypotension, Hypertension, Haemophilia, Varicose Veins, Chilblains			
Urinary problems: Cystitis, Thrush, Fluid Retention, Prostate (incl Cancer), Kidney Infections			

Skeletal , Muscular & Joints: Fractures or Breaks, Abnormalities, Osteoporosis, Postural deformities, Arthritis, Rheumatism, Whiplash, Slipped Disc, Muscular strains, Tendinitis, Osteoarthritis			
Respiratory System: Asthma, Breathing difficulties, Bronchitis, Sinusitis, Throat Infections, Pleurisy or collapsed lung			
Nervous System MS, Parkinson's, Bells Palsy, Sciatica, Epilepsy, Trapped Nerves, ME, any other nerve related disease			
Mental Function: Mental Health Disorders, Panic Attacks, Headaches, Migraines, Depression, Bipolar, Phobias, Nervous Tension, Insomnia, Stress, Eating Disorders, Drug or Alcohol Dependence			
Foot problems: Athletes Foot, Verrucae, Bunions			
Hormonal, Metabolic & Other: Hormonal Diseases, Diabetes, Thyroid, Cancer, Auto Immune disorders			
Women: Recent Childbirth, Fibroids, Breast Implants, Breast/Ovarian/Vulva Cancer			
Miscellaneous: Broken Skin, Bruises, Cuts, Scar Tissue, Recent Operations, Implants, Pains			

Do you Smoke? YES/NO How many units of alcohol do you consume in a week?.....

Are you a Vegetarian? YES/NO Do you take dietary supplements?.....

Are you on a Diet? YES/NO If so what kind?.....

How many cups of Coffee or Tea do you drink a day?.....

How many glasses of water, juice or soft drink do you have a day?.....

What exercise do you do and how often?.....

Is there a specific reason for your visit to a complementary therapist? …….

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I declare that the information that I have given is true and complete and that I am consenting to have the therapies at Trinité. I understand my details will be computerised.

Clients signature…….. Date…….

Therapists signature……..

Please note that the information on this form will not be shared with anyone else.

GP Consent required? YES/NO	Medical Indemnity signed and attached? YES/NO