STRICTLY PRIVATE AND CONFIDENTIAL

Therapists must complete all the form with the client who MUST sign the attached Consent/Disclaimer twice before treatment begins. Keep one copy for your own records and give the second to the client. Make sure you send the ORIGINAL to Harmony's office so data is kept up to date. Complete Subsequent treatment forms ON THE DAY OF THE TREATMENT to put in client's file and send a copy to the Trust to be put in their file. If client is unable to read the declaration, you must read it to them before they sign, explaining anything they do not understand.

THERAPIST NAME		THERAPY		DATE:
CLIENT INFORMATION				
Name:				M/F:
Address:				
Tel Nos: (H)	(W)	(M)	(e-mail)	
AGE			Marital Status:	Next of Kin:
Referrer:			No of children: (Female clients only)	

MEDICAL INFORMATION		
Drs. Name Address and Telephone		
Do we need permission to treat? (CHECK REFERRAL FORM/LETTER) Permission Granted?		
DIAGNOSED CONDITIONS		
Current Medical treatment and medication		
PRESENTING CONDITION		
Any supplementary information		
MEDICAL HISTORY(e.g. Operations, allergies, past conditions)		
FAMILY MEDICAL HISTORY (details serious illnesses to parents, grandparents or siblings)		
THERAPY ALREADY RECEIVED		
PREVIOUS TREATMENTS / MANIPULATIONS/ COMPLEMENTARY THERAPIES		
WHAT IS THE MAIN (NON MEDICAL) PROBLEM YOU WOULD LIKE HELP WITH		
LIFESTYLE	**PRESENTING CONDITION**	
Weight	Smoker (per day)	Alcohol (per week)
Diet	Sleep patterns	Stress level (1 low 5 high)
Energy levels(1 low 5 high)	Sports or hobbies	
General Observations		
Any supplemental information (please include any extra information we may need to know)		

CIRCULATORY AND RESPIRATORY SYSTEMS		
Palpitations	Chest Pains	Cold Extremities
Swollen Ankles	Breathlessness/Wheezing	Blood pressure
Colds/flu	DVT?	Contact GP?

SKIN CONDITION
Spots and/or rashes
Does client check regularly for Lumps (male and female clients)
Ask client to pinch skin on back of hand and release to see skin tone to check for dehydration

SENSES
Touch(numbness)
When were eyes last tested
Hearing
Taste
Smell

DIGESTIVE SYSTEM (good. v. poor)

Digestion	Diet	Appetite	Flatulence
NormalConstipation	Diarrhoea		Alternating

Sudden loss or weight gain that was not planned?
Nausea/vomiting?

MUSCULAR SYSTEM
Aches/pains — Spasms and or cramps

SKELETAL SYSTEM

Breaks or dislocations	Restriction of movement
Auto-immune conditions affecting limbs	Spinal Discomfort

NERVOUS SYSTEM (ask client to put arms out hands loose to check for any tremors
Sudden sharp Nerve Pain
Facial Nerve Pain (headaches, dental etc)

URINARY AND REPRODUCTIVE SYSTEM		
Continence/difficulty in passing water)	Urinary Blood	Urinary pain
Prostate/bladder infections		
Pregnancy (trimester and history)	Miscarriage	Menopause/PMT

NOTES:

ADMINISTRATION OFFICE
The Harty Room at The Healthy Living Centre,
Royal Road, Sheerness Kent ME12 1HH

FOR CLIENTS

I the undersigned confirm that the information I have supplied to my therapist is correct as far as I am aware. I have had explained to me any contraindications that may apply to my condition and have been referred to the Trust by a medical practitioner. My healthcare provider has referred me at my own request. As far as I am aware I see no reason why I may not receive this non-invasive holistic treatment. I understand that at no time should I stop taking any medication prescribed for me and that I am under the care of my medical team at all times. The therapy that I will receive is designed to relax me and is for my general well-being and is not a substitute for any medical treatment for my condition.

FOR CARERS
I AM A CARER

☐

I the undersigned have given as much information about any medical condition I have or that I am aware of I have asked my healthcare provider to refer me at my own request. I confirm that I can proceed with holistic therapy at my own request.

DATA PROTECTION ACT INFORMATION AND EMERGENCY PROCEDURES

I understand for my treatment progress to be charted, my records are stored on a data base for reference and communication purposes and that such data base held complies with the Data Protection Act (as amended in May 2018 to GDPR). It is not shared with anyone other The Harmony Therapy Trust, my referrer, GP or another holistic practitioner registered with The Harmony Therapy Trust. I give my permission for this information to be passed on to them.

I understand that data may be used anonymously for statistical purposes or generally to send electronic newsletters of the Trust's events or progress/invitations to participate

I also understand I have the right to have my details corrected, changed or removed upon written request at the end of the treatment should I not wish to be contacted by The Harmony Therapy Trust with newsletters or invitations.

AT NO TIME DO WE EVER SHARE ANY OF YOUR DETAILS WITH ANY OUTSIDE ORGANISATION OR THIRD PARTY

I give my permission for my GP or the Emergency Services to be contacted before, during or after my treatment if it becomes necessary.

I have read the above and confirm that I wish to proceed with holistic therapy and that I agree to my records being stored as set out above

Signed……

(PRINT NAME) …….. Date……