



Hard Copy of Client Data for Client Management System

**STRICTLY PRIVATE AND CONFIDENTIAL**

This is a paper copy of our Client Management System. Therapists must complete the all the form with the client and ask them sign the attached Consent/Disclaimer Form before treatment begins. Take a hard copy keep a copy for your own record, but make sure you send the copy to The Harmony Therapy Trust to enable the data to be kept up to date. Subsequent treatment forms must be kept in client's file and the copies sent to the Trust to be put in their file.

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

<b>MEDICAL INFORMATION</b>
Drs. Name Address and Telephone
Do we need permission to treat? (CHECK REFERRAL FORM/LETTER)    Permission Granted?
<b><u>DIAGNOSED CONDITIONS</u></b>
Current Medical treatment and medication
<b><u>PRESENTING CONDITION</u></b>
Any supplementary information
<b>MEDICAL HISTORY</b> (e.g. Operations, allergies, past conditions)
FAMILY MEDICAL HISTORY (details serious illnesses to parents, grandparents or siblings)
<b><u>THERAPY ALREADY RECEIVED</u></b>
PREVIOUS TREATMENTS OR MANIPULATIONS
ANY PREVIOUS OR CURRENT COMPLEMENTARY THERAPIES

<b>LIFESTYLE</b>	<b>PRESENTING CONDITION</b>
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)	

**GP NOTES/MEDICAL ADVICE** (please tick adding any notes you wished to be typed up)**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

NOTES**DIGESTIVE SYSTEM (good. v. poor)**

Digestion	Diet	Appetite	Flatulence
NormalConstipation	Diarrhoea	Alternating	
Sudden loss or weight gain that was not planned?			
Nausea/vomiting?			

NOTES**MUSCULAR SYSTEM**

Aches/pains	Spasms and or cramps
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**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)
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**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 WITH A MEDICAL REFERRAL**

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. 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 WITHOUT A MEDICAL REFERRAL**

I the undersigned have given as much information about any medical condition I have or that I am aware of and understand that as a carer with no known or diagnosed conditions and have been referred by a therapist or referred myself for holistic therapy that I do so at my own request. I further understand that if during the consultation the therapist believes I need medical permission before proceeding I will obtain this via referral form. If no need becomes apparent during the consultation, I confirm that I can proceed with holistic therapy at my own request. I am a healthy member of the public that is merely requesting a relaxing treatment

**DATA PROTECTION ACT INFORMATION AND EMERGENCY PROCEDURES**

I am aware that 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. It is not shared with anyone other than my GP or another holistic practitioner registered with the Harmony Therapy Trust and I give my permission for this information to be passed on to them if my therapist should consider it necessary.

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

Signed.....

(PRINT NAME) .....

Date.....



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