

# SUBSEQUENT TREATMENT FORM

NAME:	DATE:	TREATMENT NO:
ADDRESS	TELEPHONE (INCL CODE):	THERAPIST'S NAME
POSTCODE	EMAIL:	

WHAT TREATMENT IS BEING GIVEN TODAY (i.e., massage, counselling reflexology)

<b>CHECKED FOR CONTRAINDICATIONS</b>	<b>YES</b>	<b>NO</b>
DETAILS:		

**RECENT MEDICAL HEALTH SINCE LAST TREATMENT**

OPERATIONS/TRAUMA	
ILLNESSES/DISEASES	
AREA OF PAIN	
DATE OF LAST PERIOD	
ALLERGIES/SKIN PROBLEM	
CHANGES IN MEDICATION	
BOWEL FUNCTION	
ENERGY LEVELS (1 = LOW - 5 = HIGH)	
STRESS LEVELS (1 = LOW - 5 = HIGH)	




**ANY COMMENTS REGARDING LAST TREATMENT (IE CONTRA ACTIONS):**

**Please write down one or two concerns or problems the client would like most help with**




Client's concern or Problem 1

		
0	3	6
Not bothering me at all.		Bothers me greatly

Client's concern or Problem 2

		
0	3	6
Not bothering me at all.		Bothers me greatly

**WELLBEING AFTER TREATMENT TODAY**

		
0	3	6
As good as it could be.		As bad as it could be

What were the most important aspects of this session?

**DATE OF NEXT TREATMENT:**

**NB if this is the last treatment they are having with THTT you should remind the client that when treatment finishes they have the right for their details to be removed from our database upon written request in line with GDPR2018 requirements**

Please ask them for an email address if they wish list is not shared with any third party

to be added to our newsletter mailing list. This email

