THE HARMONY THERAPY TRUST
SUBSEQUENT TREATMENT FORM

PERSONAL DETAILS

NAME:	DATE:	TREATMENT NO:
ADDRESS	TELEPHONE (INCL CODE):	PATIENT REF:
POSTCODE	EMAIL:	

CHECKED FOR CONTRAINDICATIONS - PLEASE CIRCLE:	YES	NO
DETAILS:		

RECENT MEDICAL HEALTH SINCE LASTTREATMENT

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):
CURRENT CONCERNS:
TODAY'S TREATMENT PLAN:
CLIENT'S IMMEDIATE REACTION FOLLOWING TODAY'S TREATMENT:
AFTERCARE ADVICE GIVEN:
DATE OF NEXT TREATMENT: