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| Initial Consultation Form**STRICTLY PRIVATE AND CONFIDENTIAL****t**  |
| 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. |
| Client Name 🞎 M 🞎 F | **Date** |
| Address  |  |
| Phone numbers |  |
| Email |  | **DOB** |
| Emergency contact name |  | Number |  |
| GP Surgery |  | Doctor |  |
| **Referrer** | Name | Status |
| Address | Phone  |
| **Therapist Name** | **Therapy**  |
| PERSONAL HEALTH HISTORY |
| Please list any medical conditions and surgeries or hospitalisations in the last 5 years(continue overleaf if required) |
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| Current medication and treatment plan (Please give details of any upcoming surgeries and list your prescribed and over-the-counter drugs, including vitamins, inhalers, herbal and homeopathic remedies, continue overleaf if required) |
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| Lifestyle  |
| Exercise | 🞎 Sedentary (No exercise) | 🞎 Mild exercise (e.g gentle walking) | 🞎 Occasional vigorous exercise  (less than 4x/week for 30 min.) | 🞎 Regular vigorous exercise  (4x/week for 30 minutes) |
| **Diet** *Details*  | **Appetite** *Comments* |
|  |
| **Water**/ decafinated, non-alcoholic fluids daily? *You can ask the client to pinch the skin on the back of their hand to check skin tone for dehydration* | 🞎 | CupsLitres |
| Alcohol Average units per week?  | 🞎 |  **Do you smoke?** 🞎 Yes 🞎 No*Includes tobacco, vaping and recreactional drugs like cannabis* | **Allergies***List and advise location of epipen if applicable* |
| **Sports/Hobbies/Interests** |
| **Family Commitments** |
| **Treatment Goals** What main two, non-medical, benefits would you like to experience from your sessions? E.g relaxation, improved sleep, emotional support, pain relief |

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| General HEALTH |
| Do you regularly experience low mood |  🞎 Yes 🞎 No | Do you ever feel anxious |  🞎 Yes 🞎 No | Do you have trouble sleeping? |  🞎Yes 🞎No |
| Optional details |  |  | Optional details |  |  | Optional details |  |  |  |  |
|  |  |  |
| Do you suffer from depressionOptional details |  🞎 Yes 🞎 No | Current Stress levels1 (low) – 10 (high) | 🞎 | Current Energy levels1 (low) – 10 (high) | 🞎 |
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|  | **SYSTEM CHECK***Please tick if you have, or have had in the last 12 months, any symptoms in the following area and give brief details or continue overleaf*  |
| 🞎 | **Skin** eg rashes, spots lumps, sensitivity |  🞎 | **Chest/Heart** eg high cholesterol, high/low blood pressure, breathlessness, pain or palpitations |
| 🞎 | **Head/Neck/shoulder issues** eg pain, restriction of movement | 🞎 | **Nervous system/seizures**, tremors sudden sharp nerve pain |
| 🞎 | **Digestive** eg constipation, diarrhoea, alternating, nausea, vomiting | 🞎 | **Limbs** eg pain, swelling, restriction of movement,  |
| 🞎 | **Kidney/Bladder** UTI’s, urinary pain or bleeding | 🞎 | **Muscular System** e.g Spasms, cramps aches, pains |
| 🞎 | **Circulation/DVT**, cold extremities, swollen ankles, lymph/fluid problems |

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| **Additional notes and observations** *if applicable* |

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| **Initial treatment notes and aftercare advise given** |



**Declaration**

**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…………………

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