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

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

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| **CHECKED FOR CONTRAINDICATIONS** | | **YES** | **NO** |
| 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) |  | | | |

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| **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  Smiling Face with No Fill. Neutral Face with No Fill Sad Face with No Fill  0 3 6  Not bothering me at all. Bothers me greatly |
|  |
| Client’s concern or Problem 2  . Smiling Face with No Fill Neutral Face with No Fill Sad Face with No Fill  0 3 6  Not bothering me at all. Bothers me greatly |
| **WELLBEING AFTER TREATMENT TODAY**  . Smiling Face with No Fill Neutral Face with No Fill Sad Face with No Fill  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:** |

