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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:** |

