

# STRICTLY PRIVATE AND CONFIDENTIAL

Therapists must complete all the form with the client who MUST sign the attached Consent/Disclaimer before treatment begins. Keep hard copy for your own record, but 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.

THERAPIST NAME THERAPY DATE:

**CLIENT INFORMATION**

Name: M/F:

Address:

Tel Nos: (H) (W) (M) (e-mail)

DOB: Marital Status: Next of Kin:

Referrer: No of children: (Female clients only)

**MEDICAL INFORMATION**

Drs. Name Address and Telephone

Do we need permission to treat? (CHECK REFERRAL FORM/LETTER) Permission Granted?

**DIAGNOSED CONDITIONS**

Current Medical treatment and medication

**PRESENTING CONDITION**

Any supplementary information

**MEDICAL HISTORY**(e.g. Operations, allergies, past conditions)

FAMILY MEDICAL HISTORY (details serious illnesses to parents, grandparents or siblings)

**THERAPY ALREADY RECEIVED**

PREVIOUS TREATMENTS / MANIPULATIONS/ COMPLEMENTARY THERAPIES

**WHAT IS THE MAIN (NON MEDICAL PROBLEM YOU WOULD LIKE HELP WIYH**

**LIFESTYLE PRESENTING CONDITION**

Weight Smoker (per day) Alcohol (per week)

Diet Sleep patterns Stress level (1 low 5 high)

Energy levels(1 low 5 high) Sports or hobbies

General Observations

Any supplemental information (please include any extra information we may need to know)

**CIRCULATORY AND RESPIRATORY SYSTEMS**

Palpitations Chest Pains Cold Extremities

Swollen Ankles Breathlessness/Wheezing Blood pressure

Colds/flu DVT? Contact GP?

**SKIN CONDITION**

Spots and/or rashes

Does client check regularly for Lumps (male and female clients)

Ask client to pinch skin on back of hand and release to see skin tone to check for dehydration

**SENSES**

Touch(numbness)

When were eyes last tested

Hearing

Taste

Smell

**DIGESTIVE SYSTEM (good. v. poor)**

Digestion Diet Appetite Flatulence

Normal Constipation Diarrhoea Alternating

Sudden loss or weight gain that was not planned?

Nausea/vomiting?

**MUSCULAR SYSTEM**

Aches/pains Spasms and or cramps

**SKELETAL SYSTEM**

Breaks or dislocations Restriction of movement

Auto-immune conditions affecting limbs Spinal Discomfort

**NERVOUS SYSTEM (ask client to put arms out hands loose to check for any tremors**

Sudden sharp Nerve Pain

Facial Nerve Pain (headaches, dental etc)

**URINARY AND REPRODUCTIVE SYSTEM**

Continence/difficulty in passing water) Urinary Blood Urinary pain

Prostate/bladder infections

Pregnancy (trimester and history) Miscarriage Menopause/PMT

NOTES:****

**ADMINISTRATION OFFICE**

**The Harty Room at The Healthy Living Centre,**

**Royal Road, Sheerness Kent ME12 1HH**

**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 am aware that 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 if my therapist should consider it necessary.

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 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

Signed……………………………………………………….

(PRINT NAME) ………………………………………………. Date…………………