VTCT

BODY CONSULTATION SHEET

Clients name:	
Date of birth:	Phone number:
Address:	
Dr's name and contact details:	

Details to be checked every time by the working therapist

Relevant medical history and lifestyle notes			
Allergies	Yes/No	Contraceptive pill	Yes/No
Recent operations	Yes/No	Hormonal imbalance	Yes/No
Smoking	Yes/No	Menopause	Yes/No
Claustrophobic	Yes/No	HRT	Yes/No
High/Low blood pressure	Yes/No	Epilepsy	Yes/No
Heart issue/Pacemaker/Stroke	Yes/No	Diabetic	Yes/No
Constipation	Yes/No	Metal plates/Pins/IUD/Hormonal implants	Yes/No
Asthmatic/Respiratory problems	Yes/No	Any history of cancer	Yes/No
Headaches/Migraines	Yes/No	Arthritis	Yes/No
Fever	Yes/No	Limitation of body movement	Yes/No
Tension/Fatigue	Yes/No	Haemophilia	Yes/No
Back/Neck problems	Yes/No	Hepatitis B/HIV/AIDS	Yes/No
Swelling/Oedema	Yes/No	Nail/Skin diseases	Yes/No
History of DVT/Phlebitis/Embolism	Yes/No	Nail/Skin disorders	Yes/No
Regular periods	Yes/No	Eye infections	Yes/No
Pregnant/Trying to get pregnant	Yes/No		

Do you take regular medication? If **yes** please state which medication:	Yes/No
Details of recent beauty therapy treatments/cosmetic interventions in the area we propose to treat today. If **yes** please list:	Yes/No
Client general health and well being:	
Client observations/precautions:	
Date of relevant thermal/tactile/sensitivity/patch test:	

Client signature for permission to treat:	
Therapist signature:	**Date:**

Date:	
Treatment	**Comment**
Client signature:	
Therapist signature:	

Date:	
Treatment	**Comment**
Client signature:	
Therapist signature:	

Date:	
Treatment	**Comment**
Client signature:	
Therapist signature:	

Date:	
Treatment	**Comment**
Client signature:	
Therapist signature:	

Date:	
Treatment	**Comment**
Client signature:	
Therapist signature:	