Confidential 

Online Consultation Form

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel.\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History**

**Contraindications \_\_\_\_ DVT Diabetes Pregnant Epilepsy**

 **Pacemaker Flights Contraceptive pill**

**Medication:**

**Diagnosed health conditions / disease:**

**Allergies:**

**Skin conditions / type:**

**Other health issues; levels of pain, anxiety, stress etc.**

**Presenting issue**

**Treatment required**

**Declaration.**

**I confirm that the information provided is correct and that I accept the products provided and use them at my own risk. Signed Date:**