Holistic INDIGO Therapy – client record card

New Client …

TO BE COMPLETED BY THE CLIENT BEFORE EACH SESSION:

The following information is required for your safety, and to benefit your health and welfare. The following details will be treated with the strictest confidence.

First Name: ....

Last Name: ....

Date of Birth: ....

Address: ....

....

....

....

....

Email: ....

Telephone: ....

Mobile Telephone: ....

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Gender: ....

Marital Status: ....

Sexual Orientation: ....

Number & Age of Children or Dependants: ....

....

Occupation: ....

Referred By (if applicable): ....

Doctor' s Name (your doctor will not be contacted without your permission):

....

Surgery Name: ....

Doctor's Address: ....

....

....

....

....

Doctor's Telephone: ....

I confirm that the information given above is correct and complete. I will inform my therapist before receiving treatment if any of the information above changes at any time during my treatment.

Signature: ....

Print Name in Block Capitals: ....

Date: ....

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Health Check …

TO BE COMPLETED BY THE CLIENT BEFORE EACH SESSION:

The following information is required for your safety, and to benefit your health and welfare. The following details will be treated with the strictest confidence.

Are you taking prescriptive medication: YES / NO If so what: ....

....

....

Are you taking non-prescriptive medication: YES / NO If so what: ....

....

....

In the next 12 hours, will any of the following apply:

Driving or operating heavy machinery: YES / NO
Drinking alcohol: YES / NO
Using a sunbed or exposing your skin to ultraviolet light: YES / NO

Women only:

Is there a possibility you might be pregnant: YES / NO
Are you currently menstruating: YES / NO

Have you ever receive any psychotherapy or psychoanalytical treatment for any condition: YES / NO

What therapy or therapies did you receive: ....

....

....

What was the outcome of this treatment: ....

....

....

....

....

Do you suffer, or have you ever suffered, from any of the following: (If so then please give full details)

Diabetes

Kidney problems

Epilepsy

Photosensitivity

Surgery or injury to back or joints

Sensitive skin

Allergic skin rashes

Allergies

Varicose Veins Deep vein thrombosis

Heart disease High or low blood pressure

Cancer

Stroke

Asthma

Migraines

Any other condition(s): ....

....

....

....

....

I confirm that the information given above is correct and complete. I will inform my therapist before receiving treatment if any of the information above changes at any time during my treatment.

Signature: ....

Print Name in Block Capitals: ....

Date: ....

Disclaimer …

TO BE COMPLETED BY THE CLIENT BEFORE EACH SESSION:

The following information is required for your safety, and to benefit your health and welfare. The following details will be treated with the strictest confidence.

I understand that all types and forms of complementary therapies are not intended to replace allopathic/traditional medical treatment and care rather that they are intended to work side by side with these treatments. Nor are they intended to replace proper diagnoses and/or treatment by a qualified medical practitioner.

I accept that this consultation is offered as a scientific experiment only and that no specific results can be guaranteed by the therapist/practitioner/reader. I further accept that any guidance given to me is for me to consider only. Any decisions and choices that I make as a result of that guidance or this consultation are my legal and personal responsibility only, both now and in the future.

I take full responsibility for understanding and agreeing to the terms as outlined above. I further accept that the consultation offered me is not intended as a replacement for conventional medical treatment, but is a complementary therapy that is intended to work side by side with conventional treatment. Furthermore, I accept full responsibility for my own wellbeing and for reporting my physical and psychological health to my own GP/family doctor/consultant.

I confirm that the information given above is correct and complete. I will inform my therapist before receiving treatment if any of the information above changes at any time during my treatment.

Signature: ....

Print Name in Block Capitals: ....

Date: ....