Sarah Lou's - Consultation Form

Client name:	
Address:	
Date of Birth:	
Telephone:	
Email:	
Occupation:	
Doctors Name and Address:	
In case of Emergency:	
Any known Allergies:	
Any current medication / homeopathic remedies or supplements:	
Could you be / are you pregnant:	
Do you have a history of miscarriage:	
Are your periods regular:	
Are you using a contraceptive:	
Are you on HRT or similar:	
How would you rate your general health:	

Please indicate yes or no if you suffer with any of the following:

Epilepsy / seizures	Thyroid Disorders
Stomach issues	Nervous system disorders
Immune system disorders	Depression / anxiety
Cancer	Kidney Disorders
Respiratory system disorders	Diabetes
Sensitive skin	Haemophilia / blood thinners
Heart conditions	Thrombosis or embolism
High / Low blood pressure	Muscular skeletal disorders
Circulatory system disorders	Endocrine system disorders
Recent operations	Depression
Other -	
If you have answered yes to any of the above please give details:	

Do you have any specific aims or targets for your treatment?	
Treatment:	
Date of Treatment:	
Contra-Indications requiring Medical Referral or Restricting treatment:	
Treatment Details:	
Notes for future treatments:	
Aftercare advice:	

Here at Sarahlou's I take your privacy seriously and will only use your personal information to administer your account and to provide the products and services you have requested. Your personal information will be kept for a 7 year period, stored securely and not passed on to any third parties.

Please indicate below your preferred methods of communication.

Telephone ☐ Email ☐ Post ☐ Facebook ☐

I declare that the information I have given is correct and I know of no reason why the treatment cannot proceed. I have been fully informed about the treatment, the storing of my data and am happy to proceed with my treatment.

Client Signature:	Date:
Therapist Signature:	Date:

Therapists further Notes: