



**Lifestyle**

What is your stress level?  Low  Medium  High

What is your quality of sleep?  Deep  Light  Disturbed

What is your current status?  Working  Home based  Retired

What hours do you work?  Part Time  Full Time  Shift Work

How often do you exercise?  Never  Daily  Weekly

Do you smoke?  No  1-20 per day  20+

**Diet**

How would you describe your diet?  Balanced  Moderate  On the Run  Poor

How many units do you drink per day? ..... Water ..... Fresh Juices ..... Alcohol ..... Coffee ..... Tea

Any special dietary requirements: .....

**Body Concerns**  Dryness  Cellulite  Unwanted Hair  Overweight  Poor circulation  Aches/Pains  Varicose Veins  Sensitivity

Others (please detail) ..... What is your current bodycare routine? .....

**Facial Concerns**  Dryness  Sensitive  Unwanted Hair  Open Pores  Muscle Tone  Sun Damage  Broken Veins  Ageing

Oilyness  Acne  Blackheads  Whiteheads  Fine Lines/Wrinkles Others (please detail) .....

What is your current skincare routine? .....

Do you have any social events/celebrations planned in the next six months?  Yes  No (if yes please detail) .....

Do you suffer from the following?

Allergies  Eczema  Psoriasis  Asthma  Arthritis  Rheumatism  Back problems

Aches/pains  Headaches/migraines  Epilepsy  Diabetes  Heart Condition  High/low Blood Pressure

Cancer  IBS  Constipation  Thyroid Others (please detail) .....

Are you going through any of the following?  Depression  Menopause  Pregnancy  PMT  Breast Feeding

Are you taking any medication? (if so please detail): .....

Have you had surgery in the past 18 months? (if so please detail): .....

Do you have any metal plates or pins? (if so please detail): .....

**General Health**  Excellent  Good  Average  Bad

What are you hoping to achieve from your treatment? .....

Additional comments: .....

I certify that all the above details are correct and understand that should I have any medical changes since consultation, it is my responsibility to inform the therapist.

Client Signature ..... Date: .....Time: .....

Therapist's assessment/observations of area to be treated prior to treatment: .....

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Therapist Signature: ..... Date: .....Time: .....