**A picture containing drawing

Description automatically generated**

|  |  |
| --- | --- |
| Client Name: |  |
| Address |  |
| E-mail Address: |  |
| Telephone No: |  |
| Age: |  |
| *Emergency Contact* | *Name: Telephone No:* |
| GP Name & Address |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **General Health** | | | | | | | |
| Are you on any medication now? \* | Yes |  | No |  | Details: \* | | |
| Are you undergoing any tests or medical procedures? | Yes |  | No |  | Details: | | |
| Ladies only – Could you be pregnant? | Yes |  | No |  | No of weeks: | | |
| Are you breastfeeding? | Yes |  | No |  |  | | |
| Have you had any vaccinations in last six weeks? | | | Yes |  | No |  | Details: |

Are you suffering pain in any part of your body – please mark on the diagram below;



|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| What makes the pain better? | | |  | | | | | | | |
| What makes the pain worse? | | |  | | | | | | | |
|  | | |  | | | | | | | |
| Quality of Sleep  (1 is low quality) | 1 2 3 4 5 | | | Energy Levels  (1 is low energy) | | 1 2 3 4 5 | | Stress Levels  (1 stress is low) | | 1 2 3 4 5 |
| Do you eat a varied diet? | | Do you Exercise, if so how often? | | | Alcohol consumption  (indicate units) | | Water Intake  How much water? | | Hobbies / Relaxation | |
|  | |  | | |  | |  | |  | |

Medical History (please advise)

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| --- | --- |
| **Illnesses, Diseases and Disorders – Please list** | **Accidents, Injuries and Operations – please list** |
|  |  |

Do you have any issues with the following:

|  |  |
| --- | --- |
| **Skin Issues** | **Glandular** |
| Eczema Psoriasis Hair loss Dandruff  Acne Verrucas Athlete’s Foot Allergies  Severe Bruising Scar tissue  Other | Diabetes Thyroid Glandular Infections  Other |

|  |  |
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| **Skeletal and Muscular** | **Reproductive** |
| Arthritis Joint Pain Aches / Stiffness      Fractures Sprains Osteoporosis      Whiplash  Other | Irregular periods PMS Fertility Issues  Contraceptive - please state type & date of fitting  Other |

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| **Nervous** | **Renal** |
| Lack of Sensation Eye Strain bb Headaches    Tension Spasms Tinnitus Vertigo  Epilepsy ME / Chronic Fatigue Syndrome  Other | Cystitis Urinary Tract Infection  Issues passing water  Other |

|  |  |
| --- | --- |
| **Circulatory** | **Digestive** |
| Blood Pressure Heart conditions    Varicose Veins Hot flushes Chilblains  Sensitivity to cold Thrombosis / Embolism  Other | Irregular bowel movements Constipation  Haemorrhoids Stomach cramps Bloating  IBS  Other |

|  |  |
| --- | --- |
| **Lymphatic** | **Respiratory** |
| Water retention Tonsillitis Appendicitis  Other | Frequent Colds Coughs Ear infections  Bronchitis Shortness of breath Sinus  Other |

|  |  |
| --- | --- |
| **Special Senses – Any issues with** | **Lifestyle** |
| Ears Eyes Taste Smell  Other | Anxiety Depression Stressful Home  Pressurised work environment  Other |

Please read and sign

To the best of my knowledge, the information I have given is true and I have not withheld any information concerning my health. I will keep Hazel Burgess updated on my health should there be any changes to answers given. I understand there is a possibility that I may experience some minor reactions as my body adjusts to the treatment.

*(Possible reactions include; frequent visits to the toilet, runny nose or cough, slight rash as skin rebalances, perspiration, conditions which have been repressed may flare up temporarily, deep sleep or difficulty sleeping. This is not an exhaustive list*).

I understand that Hazel Burgess does not diagnose illness or any physical or mental condition. I understand that this treatment is not a substitute for medical examination, diagnosis or treatment. While I recognise that all due care will be taken by Hazel Burgess, I am aware that my participation in the treatment is voluntary.

Client Signature: ………………………………………………………………………….. Date: ……………………………………………

\*GP’s oral non-objection given: Signed by Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please see additional COVID-19 Screening Questionnaire