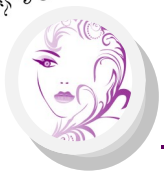

Consultation Form

First Name _____ Surname _____

Date of Birth _____ Gender _____

Address _____ County _____

Contact Tel No _____ E-mail _____

Medical History

Do you suffer from any of the following?

☐ Allergies	☐ Thyroid Problems	☐ Headaches
☐ High / Low Blood Pressure	☐ Heart Condition	☐ Varicose Veins
☐ Eczema / Psoriasis	☐ Cancer	☐ Bowel Problems
☐ Arthritis / Rheumatism	☐ Epilepsy	☐ Claustrophobia
☐ Asthma / Lung problems	☐ Back Problems	☐ Fungal infection
☐ Diabetes	☐ Muscular Problems	☐ Other

If you ticked any of the above, please give details.

Are you currently on medication or under medical supervision?
If yes please give details. ☐ Yes ☐ No

Have you had surgery or operations in the last 6 months.
If yes please give details. ☐ Yes ☐ No

Are you pregnant or breast feeding ☐ Yes ☐ No

I have read and understand the questions asked and confirm the answers given are correct and no information has been withheld.

Signed: _____ **Date:** _____