Maya's Healing Hands

Client Consultation Form

These questions are asked for your own safety. The information you provide will be treated as private and confidential, and will not be revealed to any third party without our prior consent in writing.

Please answer all questions and write clearly in CAPITAL letters. Write N/A if not applicable

Title	First Name	Last Name	Date of Birth

House No	Street Name	Town/City	County	Post Code

Occupation	Phone/Mobile Number	Email

GP Name & Phone Number	

Health Disorders/Conditions/Symptoms — Please Tick

Allergies		Emotional Problems		Menstruation Problems	
Arthritis / Rheumatism		Epilepsy		Migraine / Headaches	
Backache		Fluid Retention		Overweight	
Cancer		Heart Condition		Poor Circulation	
Cellulite		High Cholesterol		Recent Pregnancy	
Contagious Skin Conditions		Hormonal Problems		Stress	
Depression		Infertility		Thrombosis / Phlebitis	
Diabetes		Insomnia		Thyroid	
Digestive Problems		Kidney Bladder		Varicose Veins	

Other pain/conditions/symptoms not mentioned:
Recent Accidents/Injuries/Operations:
Medications (incl. Steroids, HRT etc):

Lifestyle / Diet — Please Tick

Smoking		Exercise		Healthy Diet	

Signature ---------- Date _____