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HEALTH QUESTIONNAIRE AND CONSENT FORM for David/Alan McCarthy

SECTION ONE: Client Details

Name:	
Address:	
Phone:	
E-mail:	
Date of birth:	
G.P. Name, address, telephone number:	
Occupation; general description of usual work and /or hobbies:	

SECTION TWO: Health Questionnaire
Tick the relevant box if you have any of the following conditions

Condition	√	Condition	√	Condition	√
Headaches		Digestion / Bowl problems		Respiratory problems	
Migraines		Heartburn / Reflux		Asthma	
Insomnia		Circulation problems		Bowel problems	
Diabetes		Varicose veins / Thrombosis		Urinary problems	
Epilepsy		High / Low blood pressure		Hormonal problems	
Allergies		Arteriosclerosis		Skin problems	
Pregnant / IUD		Stroke		Cancer	

Details / Notes:

Questions:	
What is the reason for needing Amatsu?	
Have you consulted anyone about the above?	
List all medication include prescribed self administered and recreational i.e. smoking:	
How much water do you drink daily?	
Do you drink Tea / Coffee	
Who referred you to the Amatsu Orthopath Clinic?	

please turn over

Specific problem details:		
Main site	Where is the pain?	
Aggravating factors	What make it worse?	
Relieving factors	What makes it easier?	
Character (sharp/dull/intermitted/ stabbing etc)	Type of pain?	
Onset	Start of onset?	
Severity	How bad is it? Is your sleep affected?	
Duration	How long does the pain last for?	
Radiation	Does the pain travel / Radiate?	
Associated magnifications	Any bruising?	
Frequency	When does it occur?	
Time	Time of occurrence?	

SECTION THREE: Statements and consent of client: Data Protection and Confidentiality

I declare that all of the aforementioned is true to the best of my knowledge. I confirm that I do not have any infectious diseases and I agree to inform the practitioner should my health condition change or deteriorate.

I understand that Amatsu uses touch and mobilisation. I consent to the practitioner holding and moving my body to facilitate the treatment.

I agree that **David and Alan McCarthy**, in accordance with the Data Protection Act 1988 may hold and process the personal data in this form and any further data relating to my treatment. All information will be treated as strictly private and confidential. Should consultation or referral be necessary, the practitioner will obtain the clients permission before disclosing any information.

I understand that failure to keep an appointment or provide notification of cancellation at least the day before will result in the full fee being charged.

Signature:

Print name:

Date: