HEALTH QUESTIONNAIRE
ALTERNATIVE HEALTH THERAPY

ALL INFORMATION IS TREATED WITH THE STRICTEST OF CONFIDENCE

PERSONAL DETAILS

Name:
Address:

Postcode:

Telephone Number:
Email Address:

Your details will not be sold to any third party. Your privacy is our highest priority.

Would you like to receive contacted regarding our monthly promotional offers. Yes / No

HEALTH DETAILS
Have you ever been diagnosed as suffering from any of the following conditions (please circle):

High Blood Pressure	Yes / No
Low Blood Pressure	Yes / No
Heart Condition (please specify) …………………………………………………	Yes / No
Diabetes	Yes / No
Asthma	Yes / No
Epilepsy	Yes / No
Deep Vein Thrombosis	Yes / No
Bleeding Disorders	Yes / No
Varicose Veins	Yes / No
Cancer (please specify) ………………………………………………………….	Yes / No
Skin Disorders (eg. psoriasis, fungal infection) ……………………………….	Yes / No
Osteoporosis	Yes / No
Inflamed Joints (please specify) …………………………………………………	Yes / No

Please list reasons for this treatment:

Please list previous injuries and or operations:

Are you susceptible to bruising?	Yes / No
Are you fitted with a pacemaker?	Yes / No
Are you fitted with any artificial joints, metal or plastic plates or pins?	Yes / No
Are you currently pregnant?	Yes / No
Is there any other medical information that you feel we should know about?	Yes / No

Please give details: ____________________

Disclaimer: Alternative therapy treatment can require the removal of some items of clothing, and certain injuries may require treatment close to personal areas. Patient privacy will be considered at all times. If you are uncertain, please ask questions prior to the commencement of your treatment. I have read and understand the above information and have no objections to the treatment required.

Patient Signature: ____________________ Date: ____________________