Consultation Form

Personal Details

Name: JUDITH HAMMOND Address: c/- 37 RIVERLINKS DRIVE CLARKSON
Phone: (Home)_____(Mobile): _____ Email: kpjc.hammond@bigpond.com
Date of Birth: 20-8-50 Do you know the time of your birth? _____ Location: NTH SUB HOSPITAL
Occupation: RETIRED Hobbies: GOLF + BOWLS
Next of Kin/Emergency Contact (Full Name): MELISSA SIMPSON Phone/Email: _____

Health Details:
Initial Reason for Treatment (relaxation, sports injury, muscle soreness etc.): RELAXATION + MUSCLE
Medication in use (for example, steroids, HRT etc.): ASPRIN - ARTHRITIS TABS
Are you Pregnant? N/A or Y/N Due Date NO.

Health Conditions/Symptoms – please tick

High/low blood pressure	NO	Diabetes		Other conditions (Please specify)
Cancer	NO	Epilepsy	NO	
Respiratory conditions	NO	Contagious skin conditions		PSORISIS
Heart Conditions	NO	Recent Pregnancy	NO	
High Cholesterol	NO	Varicose Veins		SOME
Thyroid	NO	Allergies	NO	
Thrombosis/Phlebitis	NO	Poor Circulation	NO	
Digestive problems	NO	Kidney/bladder	NO	
Stress	NO	Arthritis/rheumatism	YES	
Emotional Problems	NO	Menstruation Problems	NO	
Depression	NO	Infertility	NO	
Insomnia	NO	Hormonal Problems	NO	
Migraine/Headaches	NO	Fluid Retention	NO	
Backache	NO	Cellulite	YES	
Other Conditions	–	Overweight	YES	

Lifestyle/Diet – please circle Y/N and describe details, if possible.

Smoking Y/N – how often?	NO.	PAST 12HRS (if applicable)	
Exercise Y/N – how often?	4-5 DAYS	Fever	Y/(N)
Alcohol Y/N – how often	VERY LITTLE	Diarrhoea	Y/(N)
Water Y/N – how much per day?	LOTS.	Vomiting	Y/(N)
Tea Y/N how much per day?	SOME.	Contagious Illness	Y/(N)
Coffee Y/N – how much per day?	SOME	Under influence drugs/alcohol	Y/(N)
Vegetarian/Vegan Y/N	NO	Others not mentioned	

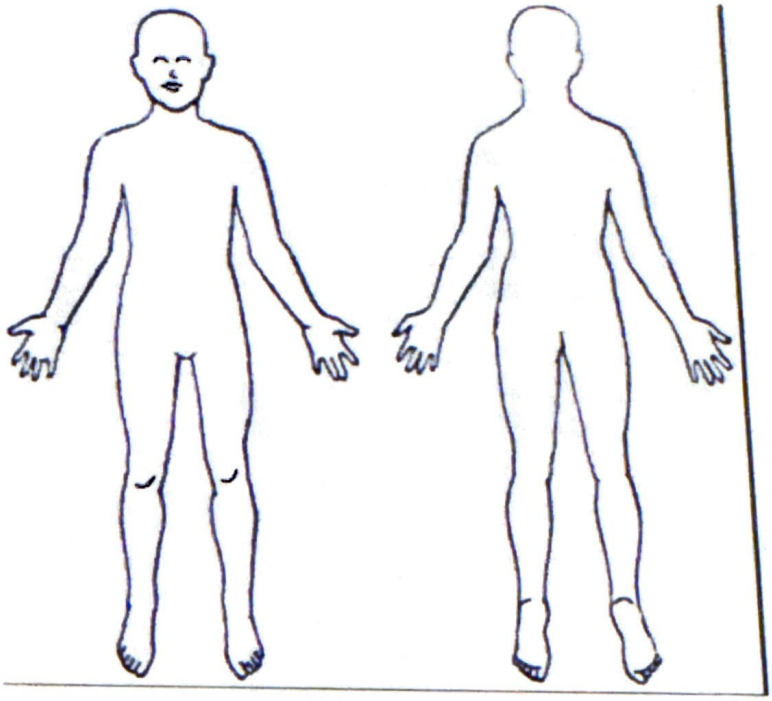
Formal Consent

I understand that the services received today, Massage Therapy, Beauty Therapy, I receive is provided for the basic purpose of relaxation, stress reduction and muscular tension and most important pure enjoyment. I further understand that the massage, skin treatment, and any other aspects relating to today's treatment should not be construed as substitute for medical examination, diagnosis, or treatment in any manner. The treatments performed today do not take the place of medical treatment where needed. If you are in doubt, please consult your doctor or physician.

Date: 6/9/19 Name: JUDY HAMMOND Signature: J Hammond

Physical Assessment (Office ONLY)

Main Observations(Office ONLY)



Consultation Form – Notes (Office ONLY)

Name: Judeta Hammond **Address:** Clarkson

6-9-19 6Y - 60 min pre relaxation massage focus on back & upper arms.

m medical treat