



## Consultation Form

### Personal Details

Name: STEVEN FILLARDI Address: 142 ST STEPHENS CRES - TAPPIN  
 Phone: (Home) 90043 (Mobile): 04077 27751 Email: SEAN@E-RELAX.COM  
 Date of Birth: 24/12/1976 Do you know the time of your birth? GPA Location: KINGSTON  
 Occupation: RETAIL Hobbies: SOCCER  
 Next of Kin/Emergency Contact (Full Name): MICHA FILLARDI Phone/Email: \_\_\_\_\_

### Health Details:

Initial Reason for Treatment (relaxation, sports injury, muscle soreness, etc.): BACK & SHOULDER  
 Medication in use (for example, steroids, HRT etc.): ANTI-DEPRESSION & COLESTROL  
 Are you Pregnant? N/A or Y/N Due Date \_\_\_\_\_

### Health Conditions/Symptoms – please tick

|                         |                                     |                            |  |                                   |
|-------------------------|-------------------------------------|----------------------------|--|-----------------------------------|
| High/low blood pressure |                                     | Diabetes                   |  | Other conditions (Please specify) |
| Cancer                  |                                     | Epilepsy                   |  |                                   |
| Respiratory conditions  |                                     | Contagious skin conditions |  |                                   |
| Heart Conditions        |                                     | Recent Pregnancy           |  |                                   |
| High Cholesterol        |                                     | Varicose Veins             |  |                                   |
| Thyroid                 |                                     | Allergies                  |  |                                   |
| Thrombosis/Phlebitis    |                                     | Poor Circulation           |  |                                   |
| Digestive problems      |                                     | Kidney/bladder             |  |                                   |
| Stress                  | <input checked="" type="checkbox"/> | Arthritis/rheumatism       |  |                                   |
| Emotional Problems      |                                     | Menstruation Problems      |  |                                   |
| Depression              |                                     | Infertility                |  |                                   |
| Insomnia                |                                     | Hormonal Problems          |  |                                   |
| Migraine/Headaches      | <input checked="" type="checkbox"/> | Fluid Retention            |  |                                   |
| Backache                | <input checked="" type="checkbox"/> | Cellulite                  |  |                                   |
| Other Conditions        |                                     | Overweight                 |  |                                   |

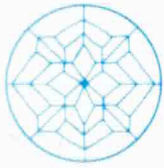
### Lifestyle/Diet – please circle Y/N and describe details, if possible.

|                                       |                    |                               |            |
|---------------------------------------|--------------------|-------------------------------|------------|
| Smoking <u>Y/N</u> – how often?       |                    | PAST 12HRS (if applicable)    |            |
| Exercise <u>Y/N</u> – how often?      | <u>WEEKLY</u>      | Fever                         | <u>Y/N</u> |
| Alcohol <u>Y/N</u> – how often?       | <u>FOUR NIGHTS</u> | Diarrhoea                     | <u>Y/N</u> |
| Water <u>Y/N</u> – how much per day?  | <u>1 GALLON</u>    | Vomiting                      | <u>Y/N</u> |
| Tea <u>Y/N</u> how much per day?      |                    | Contagious Illness            | <u>Y/N</u> |
| Coffee <u>Y/N</u> – how much per day? | <u>3 CUPS</u>      | Under influence drugs/alcohol | <u>Y/N</u> |
| Vegetarian/Vegan <u>Y/N</u>           |                    | 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: 2/8/20 Name: STEVEN FILLARDI Signature: [Signature]

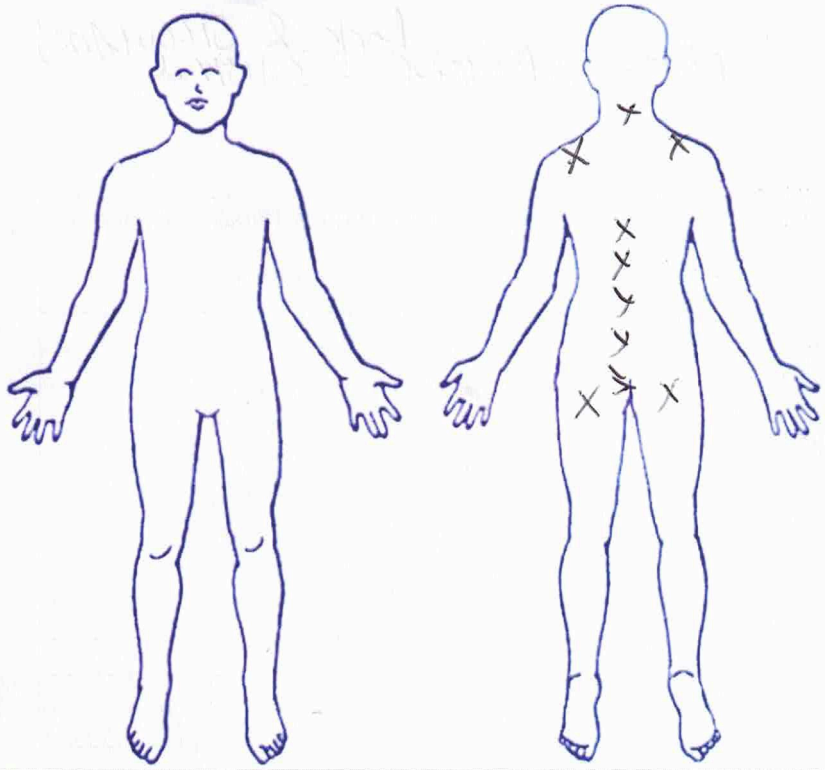


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blue.

RELAX INDULGE ENJOY

**Physical Assessment (Office ONLY)**

**Main Observations(Office ONLY)**



**Consultation Form – Notes (Office ONLY)**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

2/8/24 - notes in my appt

