

Taster Treatment Consultation Form

Name Miss/Mrs/Ms/Mr

Address and postcode

Date of Birth

Contact Telephone No.

Please detail your medical history in the last 12 months (any operations, illnesses, injuries etc.)

Do you suffer from any allergies? If yes, please give details

Are you currently taking any prescribed medication? If yes, please give details

Are you currently receiving treatment from a GP/health professional? If yes, please give details

Do you currently have any of the following conditions?

- Cancer
- Diabetes
- Epilepsy
- Fungal conditions
- Heart conditions
- Infectious diseases
- Joint problems
- Muscular problems
- Recent cut/abrasion/bruising/swelling/inflammation
- Skin disorders
- Thrombosis/varicose veins
- Unstable blood pressure
- Other

If you have answered yes to any of the above, please provide details below

Could you be pregnant? Yes No
 Have you recently consumed alcohol? Yes No
 Have you recently taken unprescribed drugs? Yes No

Declaration (Please read this section carefully and sign below)

"I the undersigned have completed the form as fully and accurately as I can. I believe the details to be correct and consent to having treatment with the practitioner detailed on this form. I release the practitioner from any negligent misrepresentation that may be contained in this form."

Signature

Print name

Date

For therapist use only

Date Treatment given/notes