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circle

Consultation Form

Personal Details

Name: Brooke Allan Address: 43 Doreidge Drive, Duncraig
 Phone: (Home) _____ (Mobile): 0414720847 Email: brooke.allan@icloud.com
 Date of Birth: 17/11/79 Do you know the time of your birth? 8am ish Location: Subiaco
 Occupation: Marriage Celebrant Hobbies: Music, running, beach
 Next of Kin/Emergency Contact (Full Name): Giam Allan Phone/Email: 0400781767

Health Details:

Initial Reason for Treatment (relaxation, sports injury, muscle soreness etc.): Remedial
 Medication in use (for example, steroids, HRT etc.): Supplements only
 Are you Pregnant? N/A or Y/N Due Date: No

Health Conditions/Symptoms – please tick

High/low blood pressure	Diabetes	Other conditions (Please specify)
Cancer <u>(Gynaecology)</u>	<input checked="" type="checkbox"/> Epilepsy	
Respiratory conditions	<input type="checkbox"/> Contagious skin conditions	
Heart Conditions	<input checked="" type="checkbox"/> Recent Pregnancy	<u>- currently seeing a Naturopath for hormonal issues</u>
High Cholesterol	<input type="checkbox"/> Varicose Veins	<u>Test</u>
Thyroid	<input checked="" type="checkbox"/> Allergies	
Thrombosis/Phlebitis	<input type="checkbox"/> Poor Circulation	<u>- no test</u>
Digestive problems	<input checked="" type="checkbox"/> Kidney/bladder	
Stress	<input checked="" type="checkbox"/> Arthritis/rheumatism	
Emotional Problems	<input checked="" type="checkbox"/> Menstruation Problems	<input checked="" type="checkbox"/>
Depression	<input type="checkbox"/> Infertility	
Insomnia	<input type="checkbox"/> Hormonal Problems	<input checked="" type="checkbox"/>
Migraine/Headaches	<input type="checkbox"/> Fluid Retention	<input checked="" type="checkbox"/>
Backache	<input type="checkbox"/> Cellulite	<input checked="" type="checkbox"/>
Other Conditions	<input type="checkbox"/> Overweight	

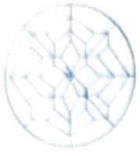
Lifestyle/Diet – please circle Y/N and describe details, if possible.

Smoking Y/N – how often?	Exercise Y/N – how often?	Alcohol Y/N – how often	Water Y/N – how much per day?	Tea Y/N how much per day?	Coffee Y/N – how much per day?	Vegetarian/Vegan Y/N	PAST 12HRS (if applicable)
<u>N</u>	<u>Y 1 time per week</u>	<u>Y - not often</u>	<u>1 litre per day at least</u>	<u>N</u>	<u>Y - 1 per day</u>	<u>N</u>	Fever <u>Y/N</u>
							Diarrhoea <u>Y/N</u>
							Vomiting <u>Y/N</u>
							Contagious Illness <u>Y/N</u>
							Under influence drugs/alcohol <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.

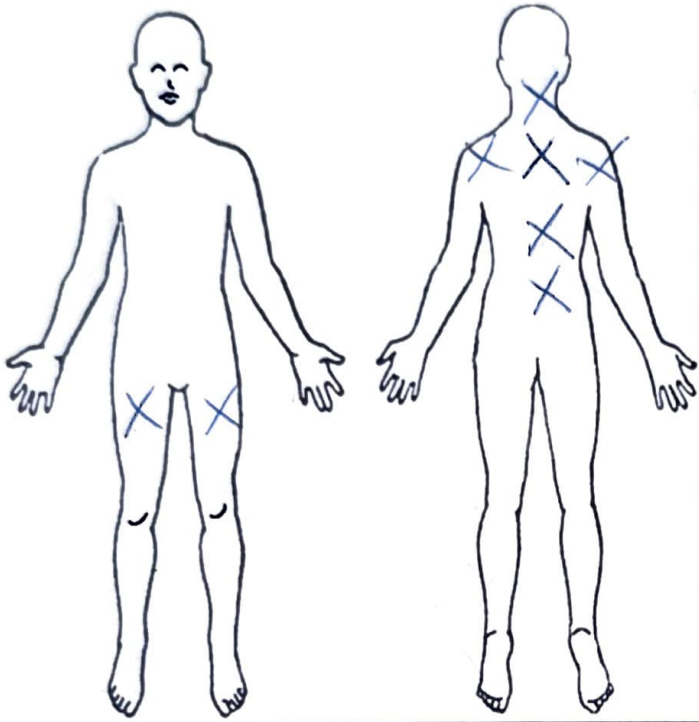
Date: 7/4/19 Name: Brooke Allan Signature: [Signature]



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NATURAL HEALTH CENTRE

Physical Assessment (Office ONLY)

Main Observations (Office ONLY)



Hx Heart monitor put in
4 weeks ago due to cardiac
arrest during routine surgery.
(Fomonty only)
- current seeing a Naturopath
for hormonal imbalance issues.

Consultation Form – Notes (Office ONLY)

Name: _____ Address: _____

14-8-19 - Brodie received a voucher from Rebecca Mahony
and she was thrilled. As no major postural issues apart
Both shoulders tight more (R) - ROM WNL; Rx - FBM focus
on PSN - Upper + shoulders (+ bi) in spine chest
+ N (R) (+); Rest of body "ok" but TrP on genital area.

