inner blue
RELAX. INDULGE. ENJOY.

Consultation Form

Personal Details

Name: Eliane Baptista Address: 48 Romano Cres Pluka

Phone: (Home)_____ (Mobile): 0438588309 Email: eliane.ls.baptista@gmail.com

Date of Birth: 19/05/1978 Do you know the time of your birth? 00:02 Location: San Pavia

Occupation: Sales Hobbies: Dance, socialize, cook

Next of Kin/Emergency Contact (Full Name): Fernando Phone/Email: 0438979750

Health Details:

Initial Reason for Treatment (relaxation, sports injury, muscle soreness etc.):_____

Medication in use (for example, steroids, HRT etc.): None

Are you Pregnant? N/A or Y/N Due Date NOT, breastfeeding ✓

acetalopran

Health Conditions/Symptoms – please tick

High/low blood pressure		Diabetes		Other conditions (Please specify)	
Cancer		Epilepsy		Anxiety Post Natal	
Respiratory conditions		Contagious skin conditions			
Heart Conditions		Recent Pregnancy			
High Cholesterol		Varicose Veins			
Thyroid		Allergies			
Thrombosis/Phlebitis		Poor Circulation			
Digestive problems		Kidney/bladder			
Stress		Arthritis/rheumatism			
Emotional Problems		Menstruation Problems			
Depression		Infertility			
Insomnia		Hormonal Problems			
Migraine/Headaches		Fluid Retention			
Backache		Cellulite	✓		
Other Conditions		Overweight	✓		

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

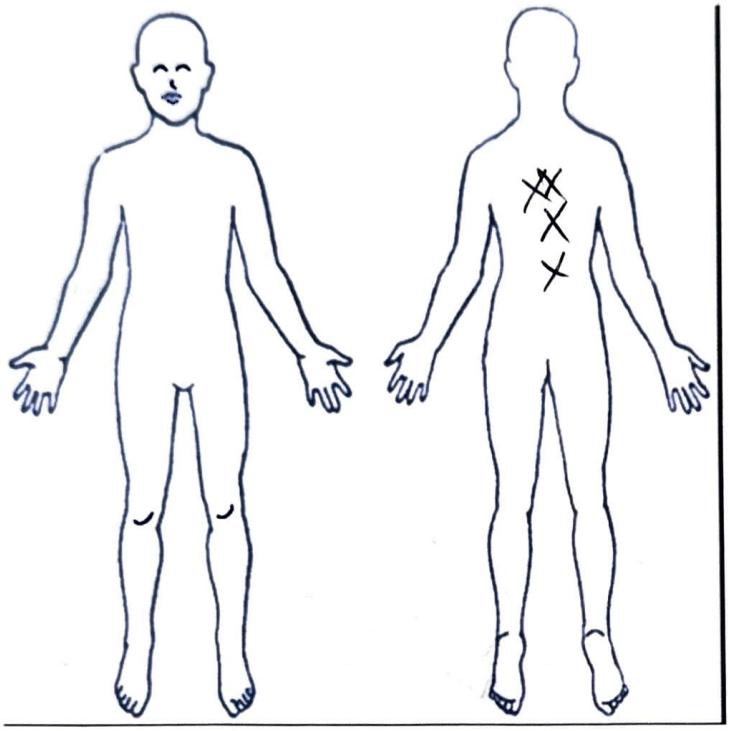
Smoking Y/(N) – how often?		PAST 12HRS (if applicable)	
Exercise (Y)/N – how often? 3×W		Fever	Y/(N)
Alcohol Y/(N) – how often		Diarrhoea	Y/(N)
Water (Y)/N – how much per day?	4L	Vomiting	Y/(N)
Tea Y/N how much per day?	1	Contagious Illness	Y/(N)
Coffee Y/N – how much per day?	2	Under influence drugs/alcohol	Y/(N)
Vegetarian/Vegan Y/N	N	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 16/12/21 Name: Eliane Signature: _____

Physical Assessment (Office ONLY)



Main Observations(Office ONLY)

- currently breastfeeding (December 21)
- Tx P
- No neuro signs
- ROM Tx / Cx / Sh WNL w/ no P / restric.
- TOS? negative test

Consultation Form – Notes (Office ONLY)

Name:_____ **Address:**_____

9-12-21 - Tx P from caring 6m old baby. Really tx Tx / Cx but DT & TrPs to release. Really responded to TrPs & P was 90% gone at the end.