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Consultation Form

Personal Details

Name: LUCLECIA CRITTENDEN Address: 60 SANTIAGO PARK WAY

Phone: (Home)_____(Mobile): 0419006722 Email: luckiajsantos@gmail.com

Date of Birth: 13/11/1988 Do you know the time of your birth? _____ Location: Goiânia

Occupation: Business Manag Hobbies: _____

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

Health Details:

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

Medication in use (for example, steroids, HRT etc.):_____

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		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?		Fever	Y/N
Alcohol Y/N – how often		Diarrhoea	Y/N
Water Y/N – how much per day?		Vomiting	Y/N
Tea Y/N how much per day?		Contagious Illness	Y/N
Coffee Y/N – how much per day?		Under influence drugs/alcohol	Y/N
Vegetarian/Vegan Y/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: 25/09/22 Name: _____ Signature: LUCLECIA CRITTENDEN

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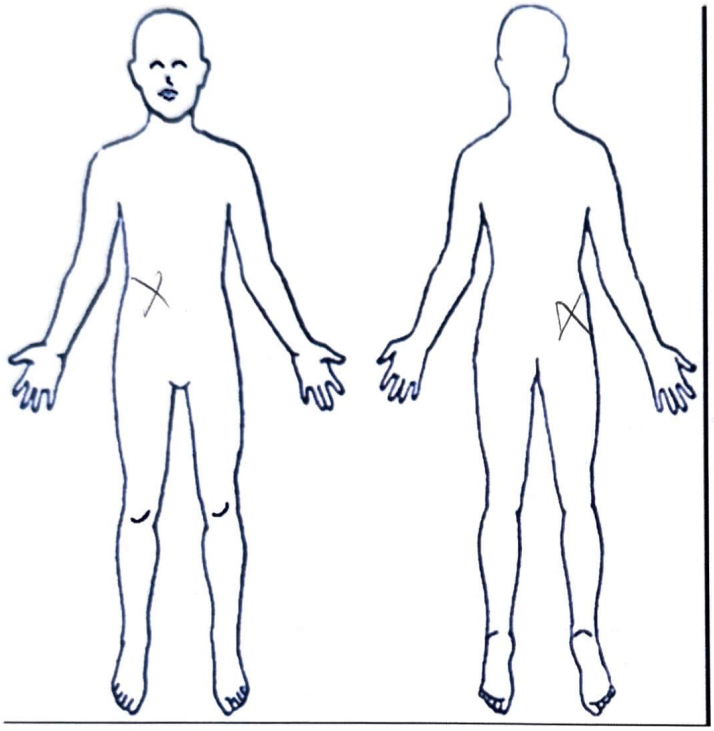
RELAX INDULGE ENJOY

Physical Assessment (Office ONLY)



Main Observations(Office ONLY)

- LBP (R)
- Hx Back (P) mostly spasm on flexion
- TAx no neuro signs
- Rom wnl sh/N/ Hip flex due to (P)
- SIJ (+)
- Hip scour (+)(bi)
- ~~Hx~~ Whiplash 20 years ago

Consultation Form – Notes (Office ONLY)

Name:_____ **Address:**_____

25-~~8~~-22 - PBM w/ hamstrings (+)(bi); glute (+)(bi). (R) P (LB, Tx | Cx) (fu) all released w/ MFR. client sensitive to pressure; gave samples of fusicream &