Consultation Form

Personal Details

Name: STEVEN FLANDI Address: 142 ST STEPHENS CRS - TOPPING
Phone: (Home) 9[illegible]2 (Mobile): 0407727751 Email: SFlandi@bigpond.com
Date of Birth: 24/2/1976 Do you know the time of your birth? 6pm Location: KENMORE
Occupation: RETAIL Hobbies: SOCCER
Next of Kin/Emergency Contact (Full Name): Nicola Flandi Phone/Email:

Health Details:

Initial Reason for Treatment (relaxation, sports injury, muscle soreness etc.): back & shoulders - ANTI-DEPRESSANT & COLESTROL
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?	WEEKLY FOOTBALL GAME	Fever	Y/N
Alcohol Y/N – how often		Diarrhoea	Y/N
Water Y/N – how much per day?	1 LITRE	Vomiting	Y/N
Tea Y/N how much per day?		Contagious Illness	Y/N
Coffee Y/N – how much per day?	2 CUPS	Under influence drugs/alcohol	Y/N
Vegetarian/Vegan Y/N		Others not mentioned	

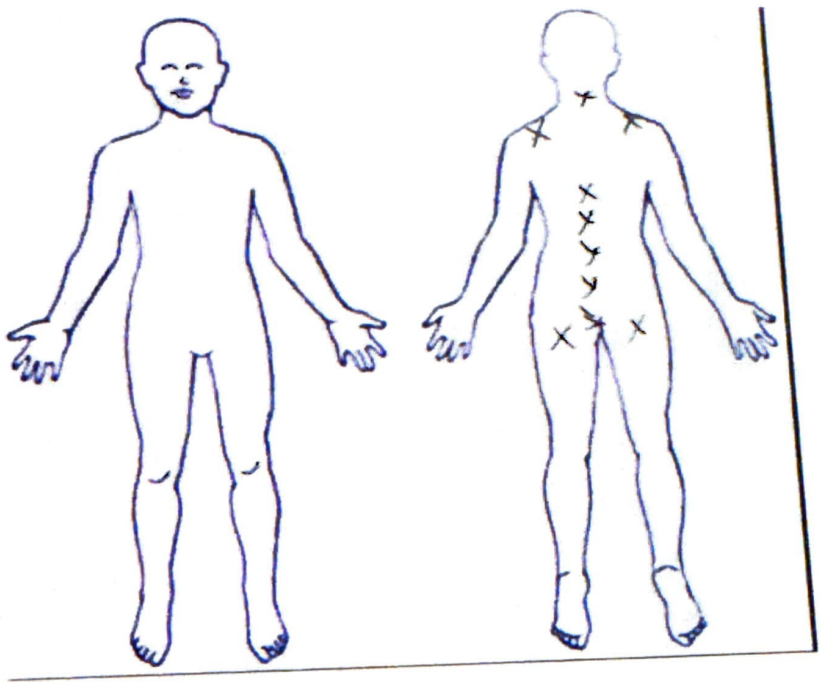
Formal Consent

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: 2/8/16 Name: STEVEN FLANDI Signature:

Physical Assessment (Office ONLY)

Main Observations(Office ONLY)



Consultation Form – Notes (Office ONLY)

Name:_____ **Address:**_____

2/8/24 - not in my appt

doctor or physician.