CONFIDENTIAL MEDICAL QUESTIONNAIRE

Therapist:

FIRST NAME **SURNAME** **Date of Birth** **Mr/Mrs/Ms/Miss/**
ADDRESS
CONTACT TEL NO **Home:** **Work**
CURRENT MEDICATION - please list medicines taken
Give details of any consultation with a Doctor or GP in the last 12 months
Give details of any other medical/emotional condition
If you have ever had any of the following, please give details: **Epilepsy** **Diabetes** **High or low blood pressure** **Skin conditions ie eczema, psoriasis etc** **Allergic reactions**
Give details of any other aches or pains
Please give details of any other issues you wish to bring to my attention?
Notes: Please list additional information overleaf. Please hand this form to the therapist before treatment.

I confirm that the above information is correct and I will advise the therapist if circumstances change. I agree to, and give authorisation for the therapy to be given.

All information is confidential including our sessions of therapy.

Signed: ..... Date: .....

Therapist: ..... Print name: .....