SALT WELLNESS RESET

CONSULTATION FORM

LAST NAME:	FIRST NAME:	TITLE:	DOB:
ADDRESS:			
MOBILE:	EMAIL:	OCCUPATION:	
GP PRACTICE:			

Medical conditions (including but not limited to diabetes, epilepsy, asthma, osteoporosis, cancer, pregnancy):

Medications:

Previous operations, hospital visits, or investigations (including approximate dates):

Allergies, or recent allergic reactions:

Do you smoke?	Average number of alcoholic drinks per week?

Do you know what your blood pressure is, or whether you tend to be high or low?

Have you a history of taking antibiotics for over 3 weeks, or more than 2 doses in a month, please give reason?

Is there a specific injury or area you'd like treated?

If yes, please give more info (aggravating and relieving factors, previous episodes, daily pattern, current treatments and investigations?

Please tell us more about yourself: (sports, hobbies, typical day e.g. desk based, family, stress levels, relaxation etc.)

PHYSICAL HEALTH QUESTIONNAIRE:

Please score each of the symptoms below according to regularity during the last month.

	Rarely	Sometimes (1/2 per week)	Often (3 per week)	Very Often (most days)	Everyday
HEAD					
Headaches:					
Dizziness on standing:					

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	Rarely	Sometimes (1/2 per week)	Often (3 per week)	Very Often (most days)	Everyday
BRAIN:					
Poor memory:					
Forgetfulness:					
Confusion:					
Bump into things:					
Poor concentration:					
MOUTH/THROAT					
Mouth ulcer:					
Bleeding gums:					
Excessive mucus:					
EYES					
Watery, itchy eyes:					
Bags, dark circles:					
Blurring vision:					
Sensitive to light:					
NOSE					
Sinus congestion:					
Running nose:					
Sneezing attacks:					
Sensitive to smells:					
EARS					
Itchy ears:					
Earache:					
Ringing in ears:					
DIGESTION					
Nausea or vomiting:					
Bloating:					
Gas/wind:					
Constipation:					
Belching:					
Loose stools:					
Abdominal cramps/pain:					
Strong smelling urine:					
LUNGS					
Chest congestion:					
Shortness of breath:					
Asthma:					
SKIN					
Acne:					
Oily skin:					
Dry skin:					
Static electric shocks:					
Athletes foot:					

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	Rarely	Sometimes (1/2 per week)	Often (3 per week)	Very Often (most days)	Everyday
Rash / itching:					
Age/sun/liver spots:					
Excessive sweating:					
Hair loss outer 1/3 of brow:					
JOINTS/MUSCLES					
Pain or aches worsened by exercise:					
Stiffness:					
Weak hand strength:					
Numbness in extremities:					
Pins and needles:					
Joints swell up:					
Chronic pain in hands, wrists, ankles, feet:					
Muscle wasting:					
Take anti-inflammatory medication:					
Chronic pain in shoulders:					
Chronic pain in hips:					
Chronic pain in back:					
WEIGHT					
Binge eating/drinking:					
Craving sugar:					
Water retention:					
No appetite:					
Insatiable thirst:					
HEART					
Palpitations:					
Chest pain:					
Cold hands/feet:					
Hot flushes:					
SLEEP					
Insomnia:					
Vivid dreams:					
Wakes during the night:					
Hard to wake up:					
Desire to nap:					
7 or more hrs sleep per night:					
IMMUNE SYSTEM					
Recurrent infection:					
Easily catches colds:					
Lumps in armpit, neck:					
Lumps in groin:					
Verruca:					
General feeling of malaise:					
Athlete's foot:					
Urinary infection:					

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EMOTIONAL HEALTH QUESTIONNAIRE

We pride ourselves in acknowledging the powerful mind/body connection in our treatment approach. We also acknowledge that these questions require vulnerability and courage! Be brave, be honest and know that all your answers confidential.

Please score each of the symptoms below according to regularity during the last month.

	Rarely	Sometimes (1/2 per week)	Often (3 per week)	Very Often (most days)	Everyday
THE LUNGS					
Possess an ambiguous attitude: either too much, or not enough					
Lack of self-confidence and lack of authority					
Unable to accept help from others					
Fear of confrontation or of bothering people					
Withdrawal and suppressed feelings					
Claustrophobia and its opposite					
Feelings of suffocating					
A need for affection and attention					
Fear or refusal to take in life fully					
THE LIVER					
Hard time knowing oneself					
Unable to let go of the past					
Consciousness of bad memories					
Tendency towards pessimism					
Lack self esteem					
A prisoner of routine					
Bad moods an ill-being					
Lack of fighting spirit					
Absence of or decrease in creativity					
A feeling of insecurity					
Bursts of anger					
Little phobias					
Depression					
THE GALLBLADDER					
Constant preoccupation and worry					
Feelings of bitterness					
Easily annoyed and irritated					
Hypersensitivity and hyperactivity					
Fear of conflict, even minor					
A need to stay in one place, routine					
Departures and separations hard to accept					
Fear of confrontation					
Extreme punctuality					
Envious tendencies					
THE INTESTINES					
Great need for security and protection					
Great need to talk					
Remarkably meticulous					

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	Rarely	Sometimes (1/2 per week)	Often (3 per week)	Very Often (most days)	Everyday
Obstinate					
Great need to convince					
Obsessing over one's health					
Tendency towards exaggeration and theatrics					
Slightly obsessive					
Certain rigidity					
Mood swings					
Sensitive and thin skinned					
Inclination toward paranoia					
Need to retain the past and possessions					
THE HEART					
Fear of not being loved and being abandoned					
Excessive attachment					
Jealousy and distrust					
Fear of judgement					
Need to be flattered and rewarded					
Fear of dying					
Reactive fear					
Guilt					
Hatred					
Fear of betrayal					
THE PANCREAS AND SPLEEN					
Social stress, fear of loss of stature					
Unbearable stress					
Unaccepted deaths					
Deep pessimism					
Deep sadness					
Longing for what might have been					
THE STOMACH AND DUODENUM					
Social stress, fear of loss of stature					
Conscious of appearance and self-image					
Extrovert					
Heightened intolerance to frustration					
Poor self esteem					
Marked ambition					
Fear of failure					
From feeling powerful to feelings of self-deprecation					
Spontaneous anger					
Needs time to get over strong annoyances					
THE KIDNEYS					
Deep seated energy reserves					
Powerful strength potential					
Fear of being defeated					
Fear of being abandoned					
Great feeling of insecurity					

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Deep seated anger					
Need to surpass oneself					
Need to lead					
Pessimism that comes in cycles					
Prefers not to go with the flow					
Poor work – life balance					
Confident in decision-making ability					
Overproduction of crushing ideas					
THE BLADDER					
Importance of control, not being able to let go					
Submissive, suppression and inhibition					
Hard time making decisions and expressing oneself					
Guilt					
Avoids tension at all costs					
Cyclical shyness					
Prudishness					
Fear of one's body not being clean					
Anxiety					

Please score yourself for how you generally feel physically, mentally and energetically:

	Poor	Fair	Good	Great	Excellent
Physical wellbeing:					
Mental wellbeing:					
Energy levels					

CANCELLATION POLICY:
Patients are required to provide 24 hour notice for any cancellation. The clinic reserves the right to charge the full fee for a missed or cancelled booking where less than 24 hours' notice is given.

PROMOTIONAL INFORMATION:
Are you happy for us to provide you with promotional information to keep you up to date with what is happening, including offers and advice, via; telephone, Email, Post? **YES / NO**

Are you happy for us to take photographs or videos of you to use on social media? **YES / NO**

OSTEOPATHY: I understand that Osteopathy is a form of complementary medicine involving the treatment of joints, muscles, tendons and ligaments.
I understand that Osteopaths use a combination of manipulation. mobilisation, soft tissue/massage, and stretching.,
I understand that treatment will involve hands on treatment to the entire body, including the chest, and pelvis.

REFLEXOLOGY: I understand that Reflexology is a therapy that works mainly on the feet, but occasionally on the hands. By working on reflex points on the feet, it can have a physiological effect on the body part that corresponds with it.
I understand that by pressing on these reflexes with fingers, one is able to bring about relaxation and balance in the body, and also assist in overall stress reduction and enhancement of wellbeing.
Patients will be asked to remove their socks and shoes.

SPORTS MASSAGE THERAPY: I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension and myofascial pain conditions suitable for treatment using soft tissue therapies.
I understand that therapy uses a mixture of soft tissue massage, stretching, muscle energy technique (MET) and soft tissue release (STR).
I understand that the therapist may ask you to remove some items of clothing in order to facilitate treatment.

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I understand that treatment will involve hands on treatment to the entire body, including the chest, and pelvis.

YOGA: I acknowledge that am physically fit and mentally capable of performing the yoga class.
I assume all risk of injuries associated with the class.
I hereby acknowledge it is my responsibility to communicate any physical concerns prior to the start of the class.

PRIVACY: I consent to you creating and storing medical records concerning my treatment, which may include details concerning my medication, treatment and other issues affecting my health conditions, in accordance with the General Data Protection Regulation (GPR).
I understand that these records will be retained for eight years, (or until I reach 25 in the case of someone aged 16-18), when treatment is ceased in order to comply legal guidance. I understand that these records will be processed in accordance with the 2018 Privacy Notice.

SIGNATURE: By signing below;

- I acknowledge that I have read and understand all parts of this consent / case history form.
- I affirm that I have stated all my known medical conditions and answered all questions honestly.
- I agree to keep the therapists updated as to any changes in my medical profile and understand that there shall be no liability on the therapists' part should I fail to do so.
- I understand that I may discontinue any treatment at any time for any reason, and if I feel uncomfortable, I should tell my practitioner.
- I understand that with any treatment there can be risks. If you have any concerns, please discuss these with your practitioner prior to treatment
- I have done a lateral flow test and confirm that it is negative and that I do not have any symptoms of Covid.
- I understand that mask wearing is not compulsory and that there is a chance of catching Covid during the day. I hold only myself accountable.
- I understand that food and drink provided is prepared in a kitchen that may contain nuts, dairy, gluten and other allergens.
- We and our hosts Gate Street Barn accept no responsibility for accidents whilst participating in the workshop.
- I have had the opportunity to ask any questions with regard to any services or therapies offered.

PRINT NAME:	**SIGNATURE:**	**DATE:**