

The Wellness Rooms

PURE • HOLISTIC • THERAPEUTIC

PERSONAL TREATMENT PLAN

THERAPIST.....

DATE.....

CLIENTS NAME.....

ADDRESS.....
.....
.....

TELEPHONE.....MOBILE.....

EMAIL.....

PLEASE TICK APPROPRIATE BOX

YES

NO

- | | | |
|--|--------------------------|--------------------------|
| 1. Do you have any medical conditions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you taking any medication? If so when did you start? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you undergoing any alternative therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any operations in the last 2 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you suffer from any allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any recent inoculations? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you under the influence of recreational drugs or alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you or could you be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

PLEASE SIGN.....

For therapists use only – recommendations, contraindications and sensible cautions checked