back2toes

professional therapy for the body and sole

BACK2TOES CASE HISTORY FORM

CLIENT RECORD CARD - STRICTLY CONFIDENTIAL

Please fill in as much of the form as possible as this will enable me to give a treatment tailor made for you. You may leave blank any section you are uncomfortable with except those coloured red. Please bear in mind that some conditions may preclude treatment or may require a doctor's referral.

Name: Ms /Miss /Mrs / Mr /Dr / Other

Address:

Postcode:

Contact tel no: Emergency tel no:

Email address:

Age: Height: Weight:

Name of your doctor or surgery: Tel no:
Address:

Current Medication:

Please note that stimulation of the circulatory systems by massage may hasten/hamper the effects of your medication.

Please circle as applicable
Married / Divorced / Separated / Widowed / Cohabiting / Single / In relationship / Other

How many children? 0 / 1 / 2 / 3 / 4 / + How old are they? …….. Are they living at home? Y / N

DO YOU HAVE A FOOT CONDITION?
Athlete's Foot? Verucca? Corn? Bunion?
Other?
Please detail eg since when? treatment?

DO YOU HAVE AN ALLERGY?
Please detail

DO YOU HAVE A RECENT INJURY?
Please detail eg since when? how did it happen? treatment?

Therapist's Notes:

Do you smoke?	No	Occasionally	Regularly	Heavy	
General fitness	Excellent	Good	Fair	Poor	
Diet	Excellent	Good	Fair	Poor	
Do you take supplements?	Various every day	One or two every day	One or two when I remember	None	
What are they?					
Fluid intake (eg water)	Excellent (up to litres a day)	Quite good	Could be better	Minimal	
Alcohol intake	None	Occasionally during week	Regularly during week	Daily, especially at weekends	
Sleep patterns	Sleep well every night, feel rested	Sleep reasonably usually	Sleep badly some of the time	Sleep badly every nigh, do not feel rested	
Energy levels	Excellent	Good	Fair	Poor	
Stress levels	Low most of time	Sometimes high	Regularly high	High all the time	
Ability to relax	Excellent	Good	Fair	Poor	
Hobbies	Lots	Quite a few	One or two	None	
Serious illness/ operation/accident	In last 20 yrs	In last 10 yrs	In last 5 yrs	In last year	
Do you suffer from any of the following?	Constipation Diarrhoea Bad skin Smelly feet Weak nails Gout Warts Headaches Shingles	Fallen arches Excess hard skin Greasy hair Negativity Inflamed bone Tiredness Varicose veins Cold sores Excessive sweating	Influenza Impetigo Dermatitis Chilblains Bursitis Folliculitis Eczema Asthma Allergies	V. high /v.low blood pressure* (+ 90 or – 50?)..... Thrombosis* Embolism* Arthritis* Hepatitis* Haemophilia* Rheumatoid Arthritis*	Heart condition* Epilepsy* Pregnancy* HRT* Diabetes* Cancer* HIV/AIDS* Lymphangitis* Pituitary/Thyroid problems*

PLEASE CIRCLE AS APPLICABLE:

Please use this space to give any further details about problem areas:
eg muscular, skeletal, digestive, excretory, circulatory, gynaecological, nervous, skin, immune system, skin?

You will be asked to sign below before your treatment can commence.

I confirm that to the best of my knowledge I have answered truthfully & not withheld any information that may be relevant to my treatment. I have understood and agreed to the treatment. I understand that the information contained herein is confidential and will not be used outside of this treatment room without my prior consent.

Client signature:	Therapist signature:	Date: