Consultation - strictly private and confidential

Client Name: _____
Address: _____
Tel: _____ ***Emergency contact:*** _____***Relationship***_____
Email address: _____
Profession: _____ ***D.O.B:*** _____/_____/_____

In order for me to carry out the safest and most beneficial treatment for you, it is necessary to ask the following questions. Please read carefully and answer all questions. Please tick either no or yes where necessary.

1, Do you have or are you currently affected by any of the following conditions:

Any form of infection, disease or fever No □ Yes □
Diarrhoea or vomiting No □ Yes □
Under the influence of recreational drugs or alcohol No □ Yes □
Botox (last 3 weeks) No □ Yes □
Recent operations No □ Yes □ _____
Any allergic reactions No □ Yes □ _____
Broken Skin No □ Yes □ _____
For women-are you in first 3 months of pregnancy No □ Yes □
For women-are you breastfeeding No □ Yes □

Diabetes	No □	Yes □	*Sunburn*	No □	Yes □
High blood pressure	No □	Yes □	*Cysts or warts*	No □	Yes □
Low blood pressure	No □	Yes □	*Eczema/psoriasis*	No □	Yes □
Cardiac patient	No □	Yes □	*Thread veins*	No □	Yes □
Heart conditions	No □	Yes □	*Contact lenses*	No □	Yes □
Blood conditions	No □	Yes □	*Conjunctivitis*	No □	Yes □
Cancer	No □	Yes □	*Depressed immune system*	No □	Yes □
Osteoporosis	No □	Yes □	*Nervous system dysfunction*	No □	Yes □
Shingles	No □	Yes □	*Undiagnosed pain*	No □	Yes □
Asthma	No □	Yes □	*Whiplash*	No □	Yes □
Contagious illness	No □	Yes □	*Trapped/pinched nerve*	No □	Yes □
Epilepsy	No □	Yes □	*Arthritis*	No □	Yes □
Cardiac pacemaker	No □	Yes □	*Dental Implants*	No □	Yes □

糖尿病
高血圧
低血圧
心臓病
心臓の状態
血液の病気
がん
骨粗しょう症
帯状疱疹
喘息
伝染病
てんかん
心臓のペースメーカー

日焼け
嚢胞／いぼ
湿疹／乾癬
クモ状静脈(静脈が皮膚から透けて見える)
コンタクトレンズ
結膜炎
免疫力の低下
神経系機能不全
診断未確定の痛み
むち打ち症
坐骨神経痛
関節炎
歯のインプラント

Other Conditions No □ Yes □ _____

2, Lifestyle: *Active □ Sedentary □ Outdoor □ Indoor □*

3, Any other diagnosed condition being treated by your home doctor or other complementary a practitioner?

_____

Are you receiving any other form of complementary therapy? _____

Disclaimer For my records, I need to confirm that you have read, understood, and answered all the previous questions. If there is anything you do not understand, please ask me. Otherwise please read the following and sign below.

*To the best of my knowledge, the information I have given is true, and I have not withheld any information concerning my health. I will keep **Yoko Taketomi Lettieri** updated on my health should there be any changes to answers given. I understand there is a possibility I may experience some minor reactions as my body adjusts to the treatment. I understand that the therapist does not diagnose illness, disease or any other physical or mental condition. I understand that this treatment is not a substitute for medical examination, diagnosis, or treatment. While I recognise that all due care will be taken by the therapist, I am aware that my participation in the treatment is voluntary.*

Please sign here: _____ *Date：* _____/_____/_____