Lianne Graham I Holistic Practitioner, Reiki Master, Reflexologist

Confidential Client Health Information

This information is considered confidential and will only be used to provide you with safe, effective treatment. If your health status changes in the future please let me know. This information may not be released without your written consent unless required by law.

Name: _____ Date of Birth: _____

Address: _____
Number and Street

_____
City Postal Code

Home Phone: _____ Email: _____

Cell Phone: _____ Occupation: _____

Referred By: _____

What is the main reason for you coming? _____

_____

☐ I would like to receive emails from Lianne with information on upcoming events, classes and healthy tips.

Please check anything that is applicable
Do you suffer from any of the following:

Currently Experienced	Previously Experiencing	
[ ]	[ ]	Heart Disease
[ ]	[ ]	Hypertension (High Blood Pressure)
[ ]	[ ]	Hypotension (Low Blood Pressure)
[ ]	[ ]	Circulatory Problems
[ ]	[ ]	Varicose Veins
[ ]	[ ]	Digestive Complaints (please list) _____
[ ]	[ ]	Epilepsy
[ ]	[ ]	Depression
[ ]	[ ]	Fatigue
[ ]	[ ]	Anxiety
[ ]	[ ]	Stress
[ ]	[ ]	Headaches/ migraines
[ ]	[ ]	Vision problems (glasses, contact lenses)
[ ]	[ ]	Hearing problems
[ ]	[ ]	Arthritis (please list where) _____
[ ]	[ ]	Respiratory problems (please list) _____
[ ]	[ ]	Do you smoke (how much) _____
[ ]	[ ]	Allergies (please list) _____
[ ]	[ ]	Skin problems (please list) _____
[ ]	[ ]	Menstrual problems (please list) _____
[ ]	[ ]	Prostate problems (please list) _____
		Urinary tract problems (please list) _____

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Are you doing any of the following? (Please give details)

Yes
[ ] Exercise (include frequency)
[ ] Relaxation techniques
[ ] Other therapies
[ ] Special food intake or diet
[ ] Might you be pregnant?

Generally, how is your health?

Have you suffered any major illness or accident? [ ] Yes Please specify:

Have you required any major operation? [ ] Yes Please specify:

Do you take any medications? [ ] Yes Please specify:

Consent for Treatment

I understand that no claim of replacing any holistic or medical therapy is made, and accordingly, no advice is given to clients that this form of treatment is superior to any other holistic or medical one.

This therapy is of a complimentary nature ONLY, rather than a curative treatment in itself. I understand that while the practitioner may make certain suggestions that may assist me, she is in no way diagnosing or prescribing on my behalf.

I _____ have listed all conditions that I am aware of and this information is true and accurate. I acknowledge that the practitioner has provided me with information regarding benefits, possible risks and side effects of the proposed treatment; I understand that I may stop the treatment at any time during the process, and I hereby give my consent for such treatment.

_____ _____

Signature Date