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amatsu therapy association

HEALTH QUESTIONNAIRE AND CONSENT FORM

SECTION ONE: Client Details

Name:	
Address:	
Phone: Home	
Work / Mobile	
E-mail:	
Date of birth:	
G.P. Name, address, telephone number:	
Occupation; general description of work and / or hobbies:	

SECTION TWO: Health Questionnaire

Tick the relevant box if you have any of the following conditions

Condition	√	Condition	√	Condition	√
Headaches		Digestion problems		Respiratory problems	
Migraines		Circulation problems		Asthma	
Insomnia		Varicose veins/Thrombosis		Bowel problems	
Diabetes		Cardiac problems		Urinary problems	
Epilepsy		High/Low blood pressure		Hormonal problems	
Allergies		Arteriosclerosis		Skin problems	
Pregnant / IUD		Stroke		Cancer	

Details / Notes:

Condition	√	Details
Skeletal disorders		
Broken / Dislocated bones		
Joint problems		
Strained muscles		
Neck pain		
Shoulder pain		
Elbow / Wrist / Hand pain		
Back pain		
Hip / Pelvic pain		
Knee / Ankle / Foot pain		

What is the reason for needing Amatsu?	
Have you consulted anyone about the above?	
List all medication include prescribed / self administered and recreational i.e. smoking:	
List all operations and approximate date:	
What is your daily fluid intake? Tea/Coffee/Water/Alcohol etc.	
Is there any other information or relevant family medical history you wish to provide?	
Where did you hear about Amatsu?	

Details / Notes:

Contra-indications:

SECTION THREE: Statement and Consent of Client. Data Protection and Confidentiality.

I declare that all of the aforementioned information is true to the best of my knowledge. I confirm that I do not have any infectious disease and I agree to inform the practitioner should my health condition change or deteriorate.

I am aware that Amatsu does not replace diagnostic tests and treatments available from my Doctor or the NHS / private medical care. I agree to retain my Doctor as my principal healthcare provider, consulting them as appropriate. I understand that I must consult with my Doctor before reducing or withdrawing any prescribed medication.

I understand that Amatsu uses touch and mobilisation. I consent to the Practitioner holding and moving my body to facilitate the treatment.

I agree that Uli Klöffel, in accordance with the Data Protection Act 1998 may hold and process the personal data in this form and any further data relating to my treatment. All information will be treated as strictly private and confidential. Should consultation or referral be necessary, the Practitioner will obtain the client's permission before disclosing any information.

I understand that failure to keep an appointment or provide more than 24 hours notification of cancellation will result in the full fee being charged.

Signature:

Print name:

Date: