Purple Sands

CLIENT HEALTH AND CONSULTATION FORM

Please complete as fully as you can. This information will be kept confidential between you and your therapist, and stored securely. Your therapist might share anonymous information about your treatment with their teacher during their supervision/mentorship meetings or future trainings, but they would not share anything that could identify which client they are referring to.

We collect your data in accordance with current privacy legislation. Please confirm that you accept for your information to be shared with your therapist, stored and used as outlined above.

**Pronouns:**

**First name:**

**Surname:**

**Name as you would like to be called (if different):**

**Address:**

**Phone number:**

**Email address:**

**Emergency contact name:**

**Emergency contact address:**

**Emergency contact phone number:**

**Date of birth:**

**Profession/movement during a typical day**   
(If you are in employment, do you usually work at a desk, standing, is it manual work, do you lift heavy items, do you move regularly or get regular breaks for movement during your work? If you are not in employment what is your lifestyle like in terms of movement?):

**Exercise and other movement**   
(Do you exercise regularly, including regular walking or cycling? Please briefly outline your usual exercise activities, frequency, intensity):

**Health conditions, medications and ongoing treatment**   
(Do you have any health conditions, such as heart/circulatory system conditions, nerve conditions, respiratory conditions, gland conditions, diabetes, infectious diseases of the respiratory or other systems, skin infections? Are you undertaking any medical treatment, including prescription medication, hormonal treatment? How are your energy levels? Is there anything that we need to avoid because of your health condition(s), or anything that you find particularly helpful?):

**Mental health** (How is your mental health at the moment? Do you suffer from any mental health conditions or conditions that might influence your stress hormones? Are you on any medication for your mental health, including psychiatric drugs?):

**Pains and aches**  
(Do you have any pains or aches? Where are they located? How long/when did the pain start? Does it feel like muscle pain or is it related to nerve compression/pathologies? Is it a dull or sharp sensation, is it at a very specific point or a large area, or does it move/occur at different parts of the body at different times? What are your pain levels currently, how do your pain levels usually vary, what tends to help and what tends to worsen the pain? Have you had treatments before, and if so how did they influence your pain levels? What have you found helpful/unhelpful in the past?)

**Allergies/skin sensitivity:**

**Please note that the oils used are organic sunflower, organic sesame, almond, peach oil, or apricot. If you have a preference, please let the therapist know at least 24hrs prior to the treatment. Acorus calamus powder is used. It is a wetland plant in the sweet flag family.**

**Priorities for treatment**  
(What would you like to get out of this treatment? E.g. we can help with overall relaxation, which can help with immune system function, sleep, energy levels and digestion; we can help with any pains and recovery from injuries; we can help with stiffness and restrictions to movement; with posture and breathing capacity. The treatment can have one or multiple objectives. It can focus on one or more areas that need attention, or we can aim to offer a full body treatment, and spread the time evenly between different parts of the body.)

**Areas to exclude from treatment**  
(Are there any areas of your body that you would prefer not to include in the treatment? Ayurvedic Yoga Massage treatments might cover massage, mobilisations and stretches of the back, shoulders, arms, neck, legs, gluteal muscles, feet, abdomen, chest for men (your therapist might also be trained in breast massage for women, but we do not usually offer this in the first treatment/without a prior discussion with the client), head and face, including the ears and light pressure on the eyes. Please let us know if you tend to get ticklish in any parts of your body, or find touch uncomfortable/painful.)

**Signature and date**