



Flying Butterflies
Relaxation.Healing.Guidance

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CONSULTATION FORM

In order for the Flying Butterflies - Istvan and Margaret Dobrila-Roth (the therapists carrying out the treatment) to deliver you the best possible treatment, we need to know details about you and your physical and mental wellbeing.

Personal Details			
Surname:			
Forename(s):		Title:	
Address:			Postcode:
Date of Birth:	Gender:	Height:	Weight:
Marital Status:	Children /Ages:		
Occupation:			
Telephone – Daytime:	Evening:		
E-mail address:			
Other contact details:			
Reason(s) for treatment:			
Expectations from treatment:			
Doctor's Name:			
			Postcode:
Emergency Contact:	Telephone:		
Relationship to contact:			

Have a look at the list below: do you - or have you ever - suffered from any of the following?
(Tick as many boxes as apply to you)

Medical History		
Urinary Tract Problems <input type="checkbox"/> Cystitis <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> Other	Ear Nose and Throat <input type="checkbox"/> Earache <input type="checkbox"/> Sinusitis <input type="checkbox"/> Sore Throat / Laryngitis <input type="checkbox"/> Other	Medical Surgical <input type="checkbox"/> Ongoing Medication <input type="checkbox"/> Pacemaker/Implant <input type="checkbox"/> Recent Surgery <input type="checkbox"/> Other
Breathing Problems <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Colds and Coughs <input type="checkbox"/> Lung infection <input type="checkbox"/> Other	Tissue Problems <input type="checkbox"/> Cellulite <input type="checkbox"/> Inflammation <input type="checkbox"/> Lymphatic Congestion <input type="checkbox"/> Bruising <input type="checkbox"/> Other	Nervous System <input type="checkbox"/> Epilepsy <input type="checkbox"/> Headache <input type="checkbox"/> Migraine <input type="checkbox"/> Neuralgia <input type="checkbox"/> Other
Circulatory Problems <input type="checkbox"/> Heart Condition <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Palpitations <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Thrombosis <input type="checkbox"/> Other	Joint and Muscle Problems <input type="checkbox"/> Arthritis <input type="checkbox"/> Back Problems <input type="checkbox"/> Gout <input type="checkbox"/> Muscular Pain <input type="checkbox"/> Muscular Tension <input type="checkbox"/> Rheumatism <input type="checkbox"/> Other	Digestive Problems <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Indigestion <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Nausea <input type="checkbox"/> Trapped Wind <input type="checkbox"/> Other

Skin Conditions <input type="checkbox"/> Acne <input type="checkbox"/> Allergic Skin Reactions <input type="checkbox"/> Burns <input type="checkbox"/> Dry/Oily Skin <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Shingles <input type="checkbox"/> Other	Mind and Mood <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Epilepsy <input type="checkbox"/> Tension <input type="checkbox"/> Insomnia <input type="checkbox"/> Mental/Emotional Exhaustion <input type="checkbox"/> Nervousness <input type="checkbox"/> Other	Other Conditions <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Increased Temperature <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pregnancy <input type="checkbox"/> Recent Injury <input type="checkbox"/> Any Other Conditions
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If you answered "Other" to any of the above, please tell us about it here:

ther relevant information:			
Are you pregnant/planning a pregnancy?	Yes / No	Months:	
Are you menopausal? If so, please list symptoms			
Do you have regular periods?	Yes / No	Date of last period if known:	
Previous Holistic Therapies		When:	
Have there been any changes in your health or medical treatments in the past week?			
Please state your Physical Wellbeing (0% - 100%):		Please state your Mental Wellbeing (0% - 100%)	

Lifestyle			
Regular meals:			
Fluid intake per day & what types:			
Balanced (please write a typical day of what you would eat)			
Alcohol intake (units per week & types)			
Do you take any Food/Vitamin supplements? If so, what?			
Do you smoke?	Yes / No	How many per day?	
Exercise	What types:		
	How Often:		
Hobbies			
How do you relax & do you find it easy or hard?			
How well do you sleep?	Good	Average	Restless
	Poor	Average hours per night:	
Do you suffer from:	Depression	Tension	Anxiety
			Stress
How do the above effect you?			

Declaration:

I declare that I have disclosed all relevant health conditions, medications and ongoing medical treatments which may affect or preclude me from receiving a therapy treatment from Istvan or Margaret Dobrila-Roth.

I accept full responsibility for any problems arising from my omission of any such details from this form.

I acknowledge that any further problems arising specifically from the delivery of this treatment are the responsibility of the "Flying Butterflies" represented by Istvan and Margaret Dobrila-Roth who are carrying out this treatment.

Any such problems, questions or comments should be addressed to Istvan or Margaret Dobrila-Roth.

Client Signature:	Date:
Therapist Signature:	Date: