

# touch of healing

109 Six House Bank, West Pinchbeck,  
Spalding, Lincolnshire. PE11 3QG

01775 888144

shehnaz@touchofhealing.co.uk

## consultation form

Name

Mr/Mrs/Miss/Ms

Telephone

Mobile

Date of Birth

Height

Weight

Address

email

Sex

male

female

Number of Children & Ages

History of injuries, illnesses & surgery

Regular physical activities/sports

Have you suffered from any of the following in the past year?

**PAINFUL**

headache  back  chest  abdomen  hip  leg

shoulder  neck  arm  pelvis  groin  buttocks

**DISORDERS**

digestion  cramps  seizures  asthma

fibromyalgia/CFS  scoliosis  depression  anxiety

**OTHERS**

**Present Medications**

**Family or General Physician / Doctor**

**Specialist**

**Explanation of current problem**

On the next page you will see diagrams. Please could you give the exact site of your pain. If the pain progresses or shoots from any area to another area, indicate the start, the path and the finished site of the pain.

**Date of Consultation**

**Signature of Client**

**FOR CLINIC USE ONLY:**

