

RAINBOWWISDOM CLIENT CONSULTATION FORM (CONTINUED)

Personal Information

Muscular/Skeletal problems: Back  Aches/pain Stiff joints Headaches

Digestive problems: Constipation Bloating  Liver/Gallbladder  Stomach 

Circulation: Heart  Blood pressure  Fluid Retention  Tired legs  varicose veins Kidney problems  Cold hands/feet 

Gynaecological: Irregular periods  PMT  Menopause  HRT  Pill other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nervous System: Migraine  Tension  Stress  Depression 

Immune System: Prone to infections  Sore Throats  Colds  Chest  Sinuses 

Regular Antibiotics taken? Yes  No  if yes which ones\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Herbal remedies taken? Yes  No  if yes which ones\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ability to relax: Good  Moderate  Poor 

Do you work at a computer? Yes  No  do you see natural daylight at work?

Are you always on the go? Yes  No would you say you are stressed? Yes  No 

Where are you on 1- 10 regarding stress 10 being the highest \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise? If yes what do you do \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you Smoke/ Yes  NO Do you Drink Yes  no  how many units a week \_\_\_\_\_\_\_\_\_

What is your skin type? Dry  Oily  sensitive  Combination  Dehydrated 

Are you allergic to nuts? Yes  No  ( \*I use ALMOND OIL in my treatments\* )

Do you suffer /have you suffered from: Dermatitis  Acne Eczema  Psoriasis  Allergies 

Hay fever  Asthma  Skin Cancer 

REASON FOR TREATMENT