

| Please circle the following. Do you suffer with or have you ever suffered with any of the following? | | Comments |
|--|----------|----------|
| Thrombosis / Phlebitis / Embolism? | YES / NO | |
| High or low blood pressure? | YES / NO | |
| A Recent operation? | YES / NO | |
| A Recent head or neck injury? | YES / NO | |
| Any dysfunction of the nervous system? | YES / NO | |
| Epilepsy? | YES / NO | |
| Diabetes? | YES / NO | |
| Recent haemorrhage? | YES / NO | |
| Heart Condition or Heart Disease? | YES / NO | |
| Circulatory problems? | YES / NO | |
| Skin disorder or infection? | YES / NO | |
| Depression/ Stress / Anxiety? | YES / NO | |
| Allergies? | YES / NO | |
| Muscular Tension? | YES / NO | |
| Arthritis? | YES / NO | |
| Any Sinus, Ear or Eye problems? | YES / NO | |
| Migraine or Headaches? | YES / NO | |
| Osteoporosis? | YES / NO | |
| Are you Pregnant? | YES / NO | |
| Are you prone to fainting? | YES / NO | |
| Do you suffer with Asthma / breathing problems? | YES / NO | |
| Is there anything else that the Therapist should be made aware of? | YES / NO | |
| <i>Details</i> | | |