Health Questionnaire

All information provided on this form, as well as information you share during your treatments is treated in the strictest confidence. Please contact me prior to purchasing/booking any treatments if you have conditions such as: Cancer (last 3 years), Parkinson's Disease, Epilepsy, Alzheimer's Disease, Severe High Blood Pressure, Multiple Sclerosis, HIV, Blood Clots, Schizophrenia, Severe Cardiac Disease, Severe Anaemia, Recent Major Surgery, etc.

Do you have any of the following? Please Circle

High/Low Blood Pressure	Y / N	Heart Condition	Y / N
Circulatory Disorder	Y / N	Epilepsy	Y / N
Arthritis/Rheumatism	Y / N	Panic Attacks	Y / N
Thyroid Problems	Y / N	Diabetes	Y / N

If you are diabetic, please make sure that you synchronise the timing of your treatment with your insulin injection. Ask for advice from your doctor.

Please list any current medication or any form of medical treatment.

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List any form of allergies, skin sensitivity, skin disorders, open wounds, verrucas, varicose veins, etc.

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Are you pregnant? If yes, how many weeks?.....
Please note if under 12 weeks pregnant I do not carry out treatments.

List any recent operations, spinal or structural injuries, head injuries:

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Please give any other information that you think is relevant.

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PLEASE CONSULT YOUR DOCTOR IF YOU ARE UNSURE ABOUT RECEIVING A TREATMENT.

Declaration:
The information provided above is to the best of my knowledge true and accurate. I confirm that I do not suffer from any condition that may prevent me from receiving my treatment @kristinaeastwood.com.

Client's Signature: ..... Printed Name: .....

EMAIL: ..... Phone No:.....

D.O.B.:..... Today's Date:.....

Your details are never passed on to other parties in strict accordance with the GDPR requirements. If you'd prefer not to receive occasional wellbeing insights and appointment updates by email, please tick here. ☐ You can unsubscribe anytime.