



claudia walker

oriental massage and acupuncture
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CLIENT RECORD

The following information is necessary for your safety and to benefit your health and will be treated in strict confidence.

Name: _____

Address: _____

Contact Tel No: _____

Date of Birth: _____

Occupation: _____

Reason for treatment

Do you have any problems? If yes, please specify and provide details. For how long have you had this problem?

Have you seen a doctor/specialist about this problem? If yes, please provide details.

Medical history: major illness, operations, injuries with approximate dates

Indicate any medical treatment and prescription medicines you are currently receiving.

Which other **complementary treatment** have you tried?

State when and indicate whether it was successful.

Are you currently having any complementary treatment(s)? Please give details.