LYFTAAL

HOLISTIC · SKIN · BODY · MIND

Welcome to Lyftaal, mom-to-be. We feel very privileged that you are entrusting us with your body care at this special time in your life. By providing us with the information below, you will give our therapists the opportunity to tailor their treatment approach to you and your baby's unique needs. Your safety and comfort are of utmost importance to us, and we will customise our treatments accordingly.

CLIENT PREGNANCY TREATMENT CONSULTATION FORM

Personal details:

NAME & SURNAME _____ DOB _____

PREGNANCY WEEK _____ DUE DATE _____

TOWN OF RESIDENCE _____ OCCUPATION _____

PHONE NUMBER _____ EMAIL _____

EMERGENCY CONTACT NUMBER _____

PRIMERY CARE PROVIDER _____

LAST VISIT TO PRIMERY CARE PROVIDER _____

Pregnancy information:

Do you suffer from any of the following pregnancy related conditions?

◯ Backache ◯ Morning Sickness ◯ Heartburn ◯ Oedema/swelling ◯ Anemia

◯ Headaches/Migraine ◯ Depression/Anxiety/Panic Attacks ◯ Diarrhea/Constipation

◯ Sciatica ◯ Urination Issues ◯ Leg Cramping ◯ Palpations ◯ Varicose Veins

◯ Clotting Issues/suspected deep vein thrombosis ◯ HBP ◯ LBP ◯ Sinuses

Any other conditions not listed here, please give detail below:

_____

What is the objective of your visit (eg relaxation/specific condition/pain)?

_____

Current Medication, incl. Supplements:

Is this your first pregnancy, please specify?

Stress levels at home? ◯ Low ◯ Medium ◯ High

Exercise/Hobbies? _____

Any known allergies? ◯ Asprin ◯ Latex ◯ Nuts ◯ Food ◯ Essential Oils

If Other, please specify _____

What is you daily water intake? ◯ 0.5 - 1 L ◯ 1 - 2 L ◯ 2 - 3 L ◯ 3 - 4 L

Have you experienced claustrophobia? ◯ Yes ◯ No ◯ Sometimes

Is there any info or concerns you would like to make your therapist aware of?

How did you hear about us?

◯ Website/Online ◯ Instagram ◯ Facebook ◯ Referral ◯ Other

If Referral, please list name _____

If Other, please specify _____

Client declaration:

I declare that the information I have given is correct and as far as I am aware I can undertake a treatment with out any adverse effects. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and I am willing to proceed. I understand that complimentary therapies do not substitute medical treatment. **If I experience any discomfort during the treatment I will inform the therapist immediately, so that the products/technique can be adjusted.** The treatments I receive here are voluntary and I release the therapist and salon from liability and assume full responsibility thereof. I understand that my therapist may require me to obtain permission from my doctor before my appointment.

◯ By checking this box I understand and accept this statement

Signature _____ Date _____