Cancer Support Scotland
Tak Tent - Take Care

COMPLEMENTARY / CHIROPODY THERAPY CLIENT RECORD

The information we collect and any additional notes that are taken during your therapy are required for your safety and to ensure our therapist can provide the best therapy for you. We also use the information on this form to collate statistics that enable us to apply for vital funding for our charity and the services we provide. The only other reason your information will be disclosed is if yours' or someone else's life is at risk or if a law has or may be broken.

Date of first visit ____/____/_____ **Name** _____ **Date of Birth** _____

Address _____ **Postcode** _____

Mobile No._____ **Home Tel no.**_____ **Is it ok to leave a message?** _____

Email Address, this is our preferred method of communication as it saves the charity money.

_____

Keeping in touch: We securely hold your details as part of a commitment to providing you with the best service we can and ensure your time with us is effective and beneficial. We intend to automatically keep you updated about Cancer Support Scotland as part of this process.

Do you want to receive updates by email? Y/N ☐ Do you want to receive updates by post Y/N. ☐

Please state any medication you are currently taking _____

Have you undergone any surgery in the last 24 months? YES / NO

If yes, please state what and when _____

Are you the person who has been diagnosed with cancer? YES / NO

Or are you a family member? YES/NO friend? YES/NO carer? YES/NO Other _____

Please state the type of cancer you, your friend or family member have been diagnosed with -

_____

Are you currently undergoing chemotherapy? YES / NO

Have you undergone chemotherapy? YES / NO

If yes, when was your last treatment? _____

Are you currently undergoing radiotherapy? YES / NO
If yes, which area? _____

Have you undergone any radiotherapy? YES / NO
If yes, when was your last treatment and which area? _____
Have you discussed any therapy with your doctor? (Before starting any therapy, we always recommend that you discuss it with your doctor). YES / NO
What is your ethnic origin? _____
Incase of emergency who would you like us to contact_____
Relationship:_____ **Telephone Number:**_____
GP Name _____ **GP Telephone Number** _____
Have you used Cancer Support Scotland Services in the past 12 months? Yes/No

If yes, where? _____**Which service did you use Counselling ☐ Complimentary Therapy ☐**

How did you hear about us? Gentle Movement ☐ Beatson ☐ Maggie's ☐ Macmillan ☐ BeatsonCharity (therapy service) ☐ Improving Cancer Journey Advisor ☐ Our Leaflet ☐ Internet Search ☐ GP ☐ Word of mouth ☐ Poster ☐ Other (please state) _____ **-PTO->**

To ensure your therapist can provide the best complementary therapy for you, please tick any of the following conditions that are relevant to you. If you have any questions about any of these, with your therapist will be happy to discuss It with you.

Allergies (inc essential oils)		**Arthritis**	
Blood Pressure, High / Low / Normal		**Chest or respiratory problems**	
Any injuries in the last 12 months?		**Muscular pain / movement problems**	
Cardiac problems		**Skin / Nails / Hair (infections / Disorders)**	
History of thrombosis / embolism		**Urinary / renal problems**	
Varicose veins / Hernia		**Reproductive / PMS**	
Any Scars (if yes, where?)		**Hormonal Problems (If yes, what?)**	
Epilepsy		**History of migraine or headaches**	
Diabetes		**Are you pregnant? (If yes, how many weeks?)**	
Kidney problems		**Nervous system disorders**	
Fatigue		**Mental health (conditions / disorders)**	
Digestive disorders		**Implants (including dental)**	
Do you have MRSA or any other infection ? Y/N Please give details and discuss with your therapist.			
Have you had any reactions to any previous complementary therapies? If yes, please give details		**If you answered yes to any of the above, please give more information or discuss with your therapist. Any further information.**	

What types of support are you interested in?

Complementary Therapies ☐ **Talking Therapies** ☐ **Group Support** ☐

Other _____

CLIENT DECLARATION: All information is confidential and will not be disclosed without your written permission. I declare that the information I have given is correct. I will update the therapist if there are any change to my medical condition.

Signed (client) _____ **Date** ___/___/_____

Signed (therapist) _____ **Date** ___/___/_____

OFFICIAL USE: Where did the therapy take place? _____

Please return your completed forms to the address below.

Cancer Support Scotland, Shelley Court, Glasgow, G12 0YN
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fundraising@cancersupportscotland.org
www.cancersupportscotland.org

Registered Charity no. SC012867