



Lomi Lomi Client Consultation

CLIENT INFORMATION & CONSENT FORM FOR TREATMENTS WITH DIANE PRZYBILLA

PERSONAL DETAILS

FIRST NAME

LAST NAME

ADDRESS

POSTCODE

EMAIL

PHONE NUMBER

DATE OF BIRTH

HOW DID YOU FIND ME?

Please tick

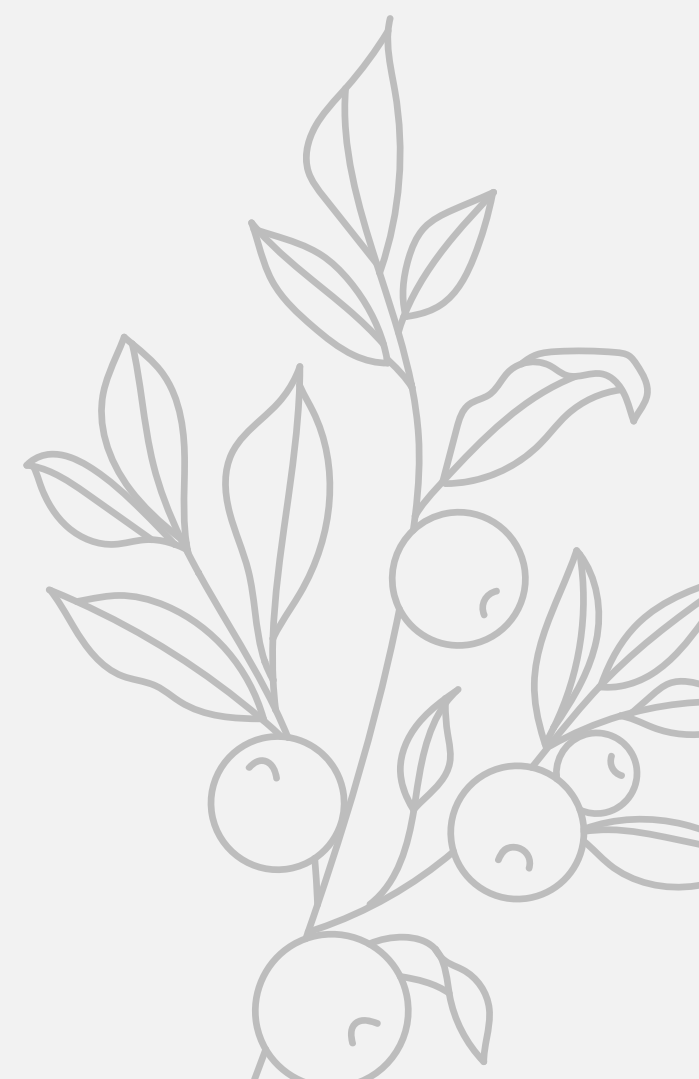
I UNDERSTAND MY PERSONAL DETAILS ARE HELD IN ACCORDANCE WITH THE DATA PROTECTION ACT. IN ADDITION TO SPECIFIC CONTACT REGARDING MY TREATMENTS I AM HAPPY TO BE CONTACTED ABOUT NEWS OR OFFERS FROM DIANE PRZYBILLA. I UNDERSTAND I MAY OPT OUT AT ANY TIME AND MY INFORMATION WILL NEVER BE SHARED WITH ANY THIRD PARTIES.

HEALTH DETAILS

Please tick

I UNDERSTAND THAT MY THERAPIST IS NOT A MEDICAL PRACTITIONER AND DOES NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS. IT IS MY RESPONSIBILITY TO LET MY THERAPIST KNOW OF ANY CONDITION FOR WHICH I AM RECEIVING MEDICAL TREATMENT.

PLEASE GIVE DETAILS OF ANY CURRENT HEALTH CONCERNS





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CLIENT INFORMATION & CONSENT FORM FOR TREATMENTS WITH DIANE PRZYBILLA

ARE YOU ALLERGIC/SENSITIVE TO:

SWEET ALMOND OIL

GRAPE SEED OIL

OLIVE OIL

SHEA BUTTER

BEE SWAX

OTHER

Please tick

I UNDERSTAND THAT DIANE PRZYBILLA IS A CTHA REGISTERED LOMI LOMI MASSAGE THERAPIST AND WILL USE BOTH TOUCH AND WORDS IN OUR SESSIONS TOGETHER. I UNDERSTAND THE TREATMENTS I RECEIVE MAY IMPACT ME IN ANY OR ALL OF THE FOLLOWING WAYS: PHYSICALLY, EMOTIONALLY, MENTALLY, ENERGETICALLY OR SPIRITUALLY. I UNDERSTAND THAT I REMAIN FULLY RESPONSIBLE FOR ANY CHANGES THAT I MAKE TO MYSELF OR TO MY LIFE. I AGREE TO LET MY THERAPIST KNOW IF I FEEL ANY DISCOMFORT DURING OUR WORK TOGETHER.

SIGNED

DATE

