Danielle M Bryant ~ Holistic Dani
Author, Teacher & Health Practitioner
Kinesiology, Homeopathy, Nutritional Therapy, Reflexology, Reiki
and the Biological Laws of Nature

NAME: _____ **DATE:** _____

MALE / FEMALE **DATE OF BIRTH:** _____

ADDRESS: _____

_____ **POST CODE:** _____

PHONE: _____ **EMAIL:** _____

CURRENT SYMPTOMS: _____

Please give details _____
of any physical _____
health problems _____
experienced at _____
present _____
_____
_____

CURRENT MEDS/
SUPPS: _____

Please give details _____
of name, strength _____
and dosage _____

** NOTE it is important to also state whether you are taking hormonal medications/supplements, e.g. HRT, birth control, etc.*

EMOTIONS: _____

Please give details _____
of any mood /sleep _____
or emotional issues _____

NOTABLE EVENTS: _____

Please give details _____
of anything shocking _____
or traumatic that _____
happened before _____
symptoms began _____

HANDEDNESS: LEFT HANDED / RIGHT HANDED *as per the clap test*

DIET: VEGETARIAN / VEGAN / EAT FISH / EAT MEAT & FISH / OTHER: _____

Notes about diet: _____

Cravings, binges _____

sweeteners used, etc _____

ALLERGIES: _____

DENTAL WORK: Silver Fillings? YES / NO How many? _____

Root Canal Fillings? YES / NO How many? _____

HISTORY: _____

Past illnesses _____

Operations _____

recurrent problems _____

** NOTE it is important if you tell me whether you have had sterilisation/ovary removal, etc and whether you re pre/post menopausal*

VACCINE HISTORY: _____

_____

_____

FAMILY HISTORY: _____

Please give details _____

of any significant _____

family history _____

SMOKER? YES / NO NO: PER DAY: _____ OTHER DRUGS? _____

OCCUPATION: _____

include past jobs with toxin exposure _____

Is there anything else that you would like me to be aware of?

Past trauma, bereavement, previous notable medication taken (such as SSRI antidepressants, radio/chemotherapy, long term or repeated use of antibiotics, steroids), previous recreational drug use, smoking etc, notable stressful times, etc

_____

_____

_____

_____

_____

I have declared all health information to the best of my knowledge and agree that advice is not to replace that of my GP or medical professional.
I confirm that I understand the treatment and I hereby indemnify the therapist against any adverse reaction sustained as a result of treatment.
I declare that I will consult my GP before undertaking any changes or stopping medications.
I understand that the therapist does not claim to cure, treat or diagnose any condition that I have.
I understand and agree to being an Associate Member of the BLNA during any interactions with Danielle M Bryant, and thereby adhere to the Code of Conduct and Constitution of the BLNA.

PLEASE SIGN IF YOU ARE IN FULL AGREEMENT OF THE ABOVE STATEMENTS _____ *signature*

Date: _____