CLIENT RECORD – PRIVATE & CONFIDENTIAL

NAME: ____________________ **DATE:** ____________

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

ADDRESS: ____________________

____________________ **POST CODE:** ____________

PHONE: ____________________ **EMAIL:** ____________

Do you suffer from any of the following:

CANCER / RHEUMATISM/ARTHRITIS / HEART CONDITION / ASTHMA / EPILEPSY / RECENT INJURY/SURGERY
BLOOD CONDITION / PSYCHOSIS/MENTAL ILLNESS / AUTO-IMMUNE / OSTEOPOROSIS / PREGNANT / DIABETES

CURRENT PROBLEMS:

Please give details of any health problems suffered at present

CURRENT MEDS/ SUPPS:

Please give details of name, strength and dosage

** NOTE it is important if you tell me whether you are taking hormonal medications/supplements such as HRT, birth control, etc*

EMOTIONS:

Please give details of any mood /sleep or emotional issues

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

Are you willing to change this if needed? YES / NO

Other notes about diet:

Cravings, binges sweeteners used, etc

ALLERGIES: ______________________________

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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*

HANDEDNESS: LEFT HANDED / RIGHT HANDED

VACCINE HISTORY: ______________________________

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FAMILY HISTORY: ______________________________

Please give details ______________________________

of any significant ______________________________

family history ______________________________

SMOKER? YES / NO NO: PER DAY: ____________ WANT TO QUIT? YES / NO

REGULAR USE OF ANY OTHER DRUGS? ______________________________

OCCUPATION: ______________________________

include past jobs that may ______________________________

have exposed you to toxins ______________________________

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

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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.

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