



Holistic Dani
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Lotus Therapy Centre, Unit 30 Venture Wales, Bedwas, Caerphilly CF83 8GF

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 _____

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 _____

other problems, _____

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

VACCINE HISTORY:

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

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