CONSULTATION FORM

Name: ____________________________ Tel No.(Home)________________ (Mobile):___________________

Date of Birth:______________________Occupation: ____

Address: ____

____Postcode: _____________________

Email Address: ____

Doctor's Name and practice: ________________ ____

Reason for this Visit/Problem areas:____

____

	Allergies		Chest pain		Hands – cold or numb		Period problems
	Anxiety		Constipation		Headache		Pins and needles
	Arthritis		Dental work		Heart problems		Pregnancy
	Asthma		Depression		Implants/stents		Sight problems
	Back pain		Diabetes		Indigestion		Sinusitis
	Bereavement		Diarrhea		Infection(s)		Skin problems
	Blood clots		Difficulty swallowing		Joint pains		Skin disorders
	Blood pressure – high		Dizziness		Lymph node removal		Sleep problems
	Blood pressure – low		Ears – "glue ear"		Migraine		Sciatica
	Breathing problems		Ears – ringing		Neck pain		Urinary problems
	Broken bones		Epilepsy		Numbness		Varicose veins
	Cancer		Feet – cold or numb		Operation		Weight loss

Please list drugs/supplements being taken and for what reason. ____

____

____

Is there anything that makes your problem area worse or better? Describe it._____________________________

____

Onset, Frequency & Duration of Problem:____

____

Have your received previous treatments for this condition? If yes, please explain. _______________________

____

Medical & Surgical History: ____

____

____

____

Are you attending your doctor? If yes, please explain. ____

____

Do you have children? ______ How many? ______ Are they well? _______

Female Clients Only: Are you pregnant? ________ When is baby due? __________

CONSULTATION FORM

General Health – (VG = Very Good; G = Good, F =Fair, P = Poor)

Appetite	VG G F P
Do you drink alcohol? If yes, how much?	Y / N ________ units per week
Relaxation:	VG G F P
Do you smoke? If yes, how many?	Y / N ______ per day
How much do you drink per day?	Water ______ litres; Tea _____ cups; Coffee ______ cups
Weight:	________ Kg ______Stone _____Pounds
How many hours per week do you work?	_____________
What percentage of your work do you find stressful?	25% 50% 75% 100%
Hearing	VG G F P
Vision:	VG G F P
Sleep	VG G F P
Skin type:	Oily, Dry, Fair, Combination, Normal
Hobbies/Interests:	
Exercise and sports:	

Is there anything else you think I should know? If yes, please specify. ________________________________

____

Have you been x-rayed or scanned recently? If yes, when, where and why? ____________________________

____

Next of kin: ________________________________ Relationship: _________________________________

Tel No.: ____

I agree that I have not withheld any information about my current state of health and that I consider myself to receive a treatment. The above information is correct to the best of my knowledge. I will notify the therapist of any future changes in my general health before receiving further treatments.

Signature: ________________________________ Date: ___________________________________