

Name: _____ M / F _____
DOB: _____
Address: _____
_____ Postcode: _____ Phone _____
Home: _____ Work: _____ Mobile Phone _____
_____ Referred by: _____
Email: _____

Client Information

Family History – please put S for self and F for family

Cancer	Kidney Disease
High blood pressure	Epilepsy
Glandular Fever /RRF	Diabetes
Asthma	TB
Heart Disease	Arthritis

Allergic to drugs/medications

Depression/anxiety

Client History - previous and current diseases and conditions

Previous viruses: _____

Main health concerns/reason for appointment

Current employment _____

Previous employment _____

Hobbies _____

Travel _____

Pets _____

Surgery _____

Scars and piercing (be specific)

Vaccinations

Do you have amalgam fillings? YES / NO

Do you have any metal implants? YES / NO

Dentures/root fillings/Crowns/bridges/implants ? YES / NO

Any sleep disturbance? YES / NO

Do you have a clock radio next to your bed? YES / NO

Do you use an electric blanket? YES / NO Pain? (be specific)

Known allergies or reactions to foods, environment or medications

Sugar cravings? YES / NO Urgent hunger? YES / NO

Daily intake of Sugar _____

Daily intake of coffee _____ Tea _____ Alcohol – How many per week _____

Vitamins/minerals intake:

Current medications:

Have you taken or had injections of ? * cortisone YES / NO *cytostatic YES / NO

Fluid intake -what volume of water do you drink per day? _____

Do you drink filtered water? YES / NO

