

						Reference No:	
Name :							
Address :							
Telephone No:							
Age :				Date of Birth :			
Occupation :							
Name of Doctor:							
Address of Doctor :							
Telephone No:							
Presenting problems :							
Medical History :							
Medication:							
Contraindications:							
Allergies :					Is it possible you could be pregnant?		
					Y / N		
Lifestyle :							
Is your general health / immunity	Good		Average		Poor		
Diet :	Good		Average		Poor	Special	
Explanation :							
Exercise :	Often		Sometimes		Never		

Stress Levels :	1	2	3	4	5	6	7	8	9	10	
Energy Levels :	1	2	3	4	5	6	7	8	9	10	
Do you find time for relaxation and hobbies? (if stressed ask about sleep and mind)											
Smoker							Non - Smoker				
Number of treatments recommended / required :											
Frequency of Treatments :											
Date of first consultation :											
Fee :						Clients Signature :					