|  |  |
| --- | --- |
| Name | Date of Birth / / M/F |
| Address:  Email:  Phone:  Profession:  Stress levels Low Medium High  Details: | Current physical issues  Muscular/Skeletal  Digestive Problems  Circulatory Problems  Gynaecological  Nervous System  Immune System |
| Medical History:  Pregnant Y/N No. of weeks:  Issues | Ability to relax: Good/ Poor Sleep: Good/ Poor  Hobbies:  Exercise:  Frequency:  Smoker: Yes/ No per day  Alcohol: Yes/ No Units/week  Food allergies: |
| Medication taken: | Diet: Fruit Veg Protein Dairy  Drinks: Tea Coffee Juice Cans Water Other  Added: Sugar Salt Sweet things |
| GP Address: | Food supplements:  Herbal supplements: |
| Skin type: | Food disorders: Overeat Under eat Bingeing |
| Allergies: | Referred by: |
| Other issues/ Important information | Other complementary therapy experiences: |
|  | |
| Reason for treatment:  This information I have provided is correct and true to the best of my knowledge. | Disclaimer/GP required: Yes/ No  Signed:  Printed:  Date: |
| Treatment 1 Notes  Treatment 2 Notes  Treatment 3 Notes  Treatment 4 Notes  Treatment 5 Notes  Treatment 6 Notes  Treatment 7 Notes  Treatment 8 Notes | Treatment 1  Date  Treatment 2  Date  Treatment 3  Date  Treatment 4  Date  Treatment 5  Date  Treatment 6  Date  Treatment 7  Date  Treatment 8  Date  Review  Date |