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| Name | Date of Birth / / M/F |
| Address:Email:Phone:Profession:Stress levels Low Medium HighDetails: | Current physical issuesMuscular/SkeletalDigestive ProblemsCirculatory ProblemsGynaecological Nervous SystemImmune 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/weekFood allergies: |
| Medication taken: | Diet: Fruit Veg Protein DairyDrinks: Tea Coffee Juice Cans Water OtherAdded: 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 NotesTreatment 2 NotesTreatment 3 NotesTreatment 4 NotesTreatment 5 NotesTreatment 6 NotesTreatment 7 NotesTreatment 8 Notes | Treatment 1DateTreatment 2DateTreatment 3DateTreatment 4DateTreatment 5DateTreatment 6DateTreatment 7DateTreatment 8DateReviewDate |