Initial Visit

Client Name:			
Address:			
Phone (Daytime):		*(Evening):*	
Gender:	☐ **M** ☐ **F**	*Date of Birth:*	
Occupation:			
GP Details			
Reasons for Consultation:			

Do you suffer, or have recently suffered, from any of the following:

Heart Condition	☐	*Cancer*	☐
Epilepsy / Seizures	☐	*HIV / AIDS*	☐
Circulatory Problems	☐	*Hepatitis*	☐
Thrombosis / Phlebitis	☐	*Recent Operations or Scarring*	☐
Diabetes	☐	*Skin Diseases or Disorders*	☐
Asthma	☐	*Recent Fractures, Sprains etc*	☐
Allergies	☐	*Swellings or Inflamed Areas*	☐
High / Low Blood Pressure	☐	*Any Other (Please give details)...*	
Disorders of the Nervous System	☐	....	

If you have answered "yes" to any of the above, please give details...

Are you currently taking any medication or receiving any treatment?

Height:		*Weight:*	
Smoking:		*Alcohol:*	
Exercise Habits			
Diet / Fluid Intake:			
Sleep Patterns:			

The information I have given is correct, and I am therefore willing to proceed with the session that has been recommended. I appreciate that holistic practitioners do not give medical diagnosis or treatment. I understand that my GP is medically responsible for me and my dependants.

Signed: **Date:**