CLIENT INFORMATION RECORD (All information confidential)

Name

	D.O.B.	

Address

Postcode | Occupation

Tel. home | Tel. mobile/work

Email

Height & weight | Hobbies

Do you have any children? ☐ No ☐ Yes – what age range?

G.P. name and address

How did you hear about us?

1. Main health issues and problems now:

2. Previous/other illness/accidents/surgery that you have had:

3. Your thoughts and hunches on possible factors linked to your health issues:

4. List any medications (and supplements) you are currently using and their intended function:

5. What is your daily *water* intake? (not including fruit juice, soft drinks, herbal tea, tea, coffee, alcohol)
   ☐ 2 litres ☐ 1 litre ☐ 500 ml ☐ Less

6. Describe your diet:

Breakfast:

Lunch:

Dinner:

Snacks:

Other drinks than water:

Are you following any diet plans? (vegan, vegetarian, gluten free, dairy free, paleo)

Do you have any known intolerances or allergies?

7. Are your bowel movements: ☐ Daily ☐ More than daily ☐ Less than daily
8. On a scale of 1-10 what is your daily energy level:
9. Do you sleep well: ☐ Yes ☐ No – why not?
10. Do you smoke cigarettes? ☐ No ☐ Yes – how many?

I*f you are female:*

11. Are you pregnant? ☐ No ☐ Yes – how advanced?
12. Menstrual cycle: ☐ regular ☐ irregular ☐ painful ☐ heavy ☐ menopausal
13. Other info

Signed: Date:

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