

**CLIENT INFORMATION RECORD** (All information confidential)

Name

	D.O.B.	
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Address

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Postcode  Occupation

Te l. 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:

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

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

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

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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?

*If you are female:*

11. Are you pregnant?  No  Yes – how advanced?

12. Menstrual cycle:  regular  irregular  painful  heavy  menopausal

13. Other info

Signed:

Date: