



CLIENT CONSULTATION FORM – CONFIDENTIAL 1/2

PERSONAL DETAILS

Name:

Address:

Telephone & email:

Age & DOB:

GENERAL LIFESTYLE: (please circle any that apply)

Lifestyle: Very Active Quite Active Sedentary Hours exercise per week:

Daily energy level (1, Poor –10, Excellent): 1 2 3 4 5 6 7 8 9 10

Overall Stress Level 1 (low) to 10 (high): 1 2 3 4 5 6 7 8 9 10

Please briefly describe the health problem(s) you would like to resolve:

Regular medications: Yes – No If yes, please list:

Ability to relax: good moderate poor

Sleep Patterns: good moderate poor Hours per night:

Type of work:

Workplace: natural daylight? Yes No

Diet: Good Moderate Poor

Smoke: Never Occasionally Often

Alcohol: Never Occasionally Often

Food/Vitamin supplements taken:

Caffeine & Water intake (daily):



CLIENT CONSULTATION FORM – CONFIDENTIAL 2/2

PHYSICAL: (please circle any that apply)

Muscular/Skeletal: Backache/Pains Shoulder Aches/Pains Stiff joints Headaches
Orthotics in shoes Wisdom teeth Any Breaks/Fractures? Hospitalisation?
(pls. detail any of above that apply):

Digestive: Constipation Bloating Stomach (acid reflux etc.)

Circulation: Heart Blood Pressure (H/L) Fluid Retention Varicose veins Kidney
problems Cold hands/feet

Nervous system: Migraines Tension Stress Depression

Immune System: Prone to: infections – sore throats – colds – chest – sinuses

Gynaecological: Pregnant (Trimester 1 2 3) Periods (irregular, painful, light)
PMT Menopause HRT Breast Implants

Skin Type: Normal Dry Oily Sensitive Dehydrated

Any: Dermatitis Acne Eczema Psoriasis Allergies Hayfever
Asthma Skin Cancer

Signed:

[client]

[therapist]