REGISTRATION FORM

All information contained on this form will be handled in strict confidence and no details will be passed on to any third party unless with the express permission of you, the client. This form will be held in safe keeping by the therapist as record of your treatment.

I AM HAPPY FOR MY DETAILS TO BE KEPT IN THIS MANNER AND FOR THIS REASON YES / NO

Name……………………………………………………………………………..…

Address……………………………………………………………………………

……………………………………………………………………….…………..…

………………………………………………………………..…………….…..…

Best Telephone number to reach you on…………………………..……………….

Best time to call_……………………………………………………………………………………..……………..

Email address for mid appointment support ……………………………………….

Date of Birth………………………………………………Age…………….……

Height………………… Weight……………………Blood Group if known………

GP's name…………………………………………………………..

Address…………………………………………….......................

………………………………………………………………………………………

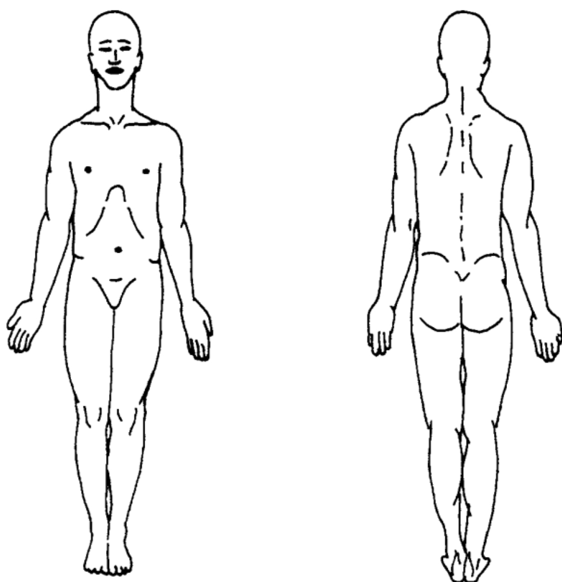
GP's tel. no………………………………………………………........

Please indicate the main reason for your consultation.

What do you hope to achieve from treatments?

How long do you expect this to take?

How much pain do you currently have? Please mark where you feel pain, discomfort, swelling and write anywhere in this area. If you can add the level of pain on a scale of 0 (no pain) to 10 (great pain) that would be helpful.



Space for more information here...

Amount of water drunk per day
(Not including fruit juices, tea, coffee etc)

Do you smoke? Yes/No

Do you take nutritional supplements? Yes/No

Please list your choice of supplements.

Outline average daily / weekly exercise taken

On the following scale, please circle your current perceived stress level

(O is no stress, 10 is severe stress)

1 2 3 4 5 6 7 8 9 10

Relating to sleep, please tick the following that apply to you;

Kept awake by racing thoughts
Restful sleep
Woken up by pet in bedroom
Wake up feeling refreshed
Wake up to use bathroom (is there a particular time?)
Woken by pain
Woken up by restless partner / children
Grind teeth
Wake up feeling exhausted
Vivid dreams

Medical History

Ongoing illnesses, injuries and afflictions (please tick all that apply)

Eczema
Heart palpitations
Epilepsy
Asthma
High blood pressure
Sciatica/back problems
Psoriasis
High cholesterol
Arthritis
Acne/other skin conditions
Diabetes
Dizziness
Rheumatism
Allergies (including to medical drugs)
Autoimmune conditions...
Other (please list)

Previous illnesses (including childhood illnesses)

Recurring problems (please tick all that apply)

Cystitis
Digestive problems
Unexplained fatigue
Thrush
Indigestion
Skin rashes
Painful periods / bloating
Constipation
Ear infections
Hot flushes
Diarrhoea
Hay fever
PMT / PMS
IBS
Conjunctivitis
Poor memory
Migraines / headaches
Hair loss
Other (please give details) ....

Family illnesses (please tick all that apply)

Heart disease
Arthritis
Eye problems
High blood pressure
Rheumatism
Osteoporosis

Circulatory problems Diabetes Cancer

Injuries / accidents (please indicate all that apply and specify when / how you got the injury)

Broken bones ……………………………………………………………………………………………………

Whiplash………

Head injury ………………………………………………………………………………………………………

Tailbone injury…………………………………………………………………………………………………

Operations / surgery ……………………………………………………………………………………

Other………

Are you currently taking any medications prescribed for you by your GP? Please give details (name of medication and what condition you are taking it for). Please also include any contraceptive pill/device if applicable.

When your last course of antibiotic and what was it for?

Have you been vaccinated recently (holiday vaccines, booster shots)? Yes/No

Please state what they were.

Do you have, or think you have, any known allergies e.g. hay fever, penicillin, aspirin, animals or food intolerances? Yes/No
Please provide brief details

Do you have dental fillings? If so, how many and type (e.g. amalgam, gold, porcelain)?

Do you still have any infant teeth? If so how many

Please read the following information carefully

This treatment (or any advice given to you by the therapist) is not intended to diagnose any medical condition or illness, nor to replace or supersede any medical treatment or advice given to you by your doctor (GP) or any other medical specialist.

Signed……

Print name……………………………………………………………………………………Date……………………