Heybridge **Holistics**

Client consultation Form

Name:		Date of Birth:		Occupation:	
Address:					
Tel No:		eMail Address:			
GP Details:					

	Question	No	Yes	Comments
CARDIOVASCULAR	Chest pain?			
	Shortness of breath?			
	Persistent coughing?			
	Palpitations			
DIGESTIVE	Constipation?			
	Diarrhoea?			
	Nausea?			
URINARY	Problems passing water (urination)?			
	Burning sensation on urination?			
	Changes in frequency of urination?			
REPRODUCTION	Changes in menstrual cycle?			
	Pregnant?			
	Menopausal?			
GENERAL HEALTH	Are you on any prescribed medication?			
	Any major illnesses?			
	Any major accidents?			
	Any major operations?			
	Anything else not mentioned?			

Reason for visit:	

CONTRAINDICATIONS	None:		Localised to:		Medical approval obtained:	

By signing I confirm that the information given in this form is true, complete and accurate to the best of my knowledge	

I would like to assure you that your personal information will be stored securely, remain confidential and will only be used for treatment purposes and will therefore not be shared with any third parties without express prior permission.

I would like to keep in touch with you from time to time when I have information regarding new treatments and special offers which I think might be of interest to you. If you agree to be contacted in this way, please confirm below the mediums through which you are happy to be contacted:

☐ **Post** ☐ **eMail** ☐ **Telephone** ☐ **SMS**

If you have ticked one or more of the boxes above, please note that your data will only be used to send you information directly from me and will not be shared with any other third parties or agencies. You can change your preferences or remove your consent at any time simply by contacting me by telephone or eMail or simply by speaking to me in person.