

## Initial Visit

<i>Client Name:</i>			
<i>Address:</i>			
<i>Phone (Daytime):</i>		<i>(Evening):</i>	
<i>Gender:</i>	<input type="checkbox"/> <b>M</b>	<input type="checkbox"/> <b>F</b>	<i>Date of Birth:</i>
<i>Occupation:</i>			
<i>GP Details</i>			
<i>Reasons for Consultation:</i>			

*Do you suffer, or have recently suffered, from any of the following:*

- |  |                          |   |                          |
|--|--------------------------|---|--------------------------|
| <i>Heart Condition</i>                 | <input type="checkbox"/> | <i>Cancer</i>                             | <input type="checkbox"/> |
| <i>Epilepsy / Seizures</i>             | <input type="checkbox"/> | <i>HIV / AIDS</i>                         | <input type="checkbox"/> |
| <i>Circulatory Problems</i>            | <input type="checkbox"/> | <i>Hepatitis</i>                          | <input type="checkbox"/> |
| <i>Thrombosis / Phlebitis</i>          | <input type="checkbox"/> | <i>Recent Operations or Scarring</i>      | <input type="checkbox"/> |
| <i>Diabetes</i>                        | <input type="checkbox"/> | <i>Skin Diseases or Disorders</i>         | <input type="checkbox"/> |
| <i>Asthma</i>                          | <input type="checkbox"/> | <i>Recent Fractures, Sprains etc</i>      | <input type="checkbox"/> |
| <i>Allergies</i>                       | <input type="checkbox"/> | <i>Swellings or Inflamed Areas</i>        | <input type="checkbox"/> |
| <i>High / Low Blood Pressure</i>       | <input type="checkbox"/> | <i>Any Other (Please give details)...</i> |                          |
| <i>Disorders of the Nervous System</i> | <input type="checkbox"/> | .....                                     |                          |

*If you have answered "yes" to any of the above, please give details...*

*Are you currently taking any medication or receiving any treatment?*

<i>Height:</i>		<i>Weight:</i>	
<i>Smoking:</i>		<i>Alcohol:</i>	
<i>Exercise Habits</i>			
<i>Diet / Fluid Intake:</i>			
<i>Sleep Patterns:</i>			

The information I have given is correct, and I am therefore willing to proceed with the therapy that has been recommended. I appreciate that holistic therapists do not give medical diagnosis or treatment. I understand that my GP is medically responsible for me and my dependants.

**Signed:**

**Date:**