CLIENT DETAILS – INITIAL CONSULTATION

Date of visit　　　　　　　　　　　　　　　　Source of referral

PERSONAL DETAILS

Title		Name			
			Last	First	Second

Gender		DOB		Age Range		Marital Status	

CONTACT DETAILS

Home Ph		Work Ph		Mobile Ph	
Email Address					
Mailing Address:					
Suburb / City		State		Post Code	
Street Address:					
Suburb / City		State		Post Code	

EMERGENCY CONTACT DETAILS

Next of Kin	
Name	Phone
Address	

FAMILY

Siblings	Yes / No	No of Sis		No of Bros		
Children	Yes / No	No of Girls		No of Boys		

Parents - Alive	Yes / No	Married	Yes / No	Remarried	Yes / No	

Comment Genetic History

OCCUPATION

Occupation				
Date Commenced		Length employment		Environment

MEDICAL HISTORY

Primary Health care provider	Medical	Alternative	
Name & Type of practitioner			Ph:

Prescribed Medication / Supplements / Remedies

GENERAL HEALTH　　　　　　　　BLOOD GROUP:

Known medical conditions, physical symptoms and location. Treatment advised

GENERAL HEALTH - Continued

Emotional	
Bowel Habits	
Diet	
Sleep Patterns	
Exercise	
Sensitivities / Allergies	
Lifestyle(stressful, smoking, drugs, alcohol)	
Exposure to Pollution	

History

Childhood Illnesses (incl. age)	
Adult Illnesses (incl. age)	
Accidents, Injuries, Operations, Hospitalisations (incl. age)	
Vaccinations – Illnesses or Consequences	
Mercury Amalgams and Root canals	

Self Evaluation of Present Condition	Scale of pain / discomfort / energy level / loss of physical function
Least 1 2 3 4 5 6 7 8 9 10 Most	