Body-worker
Gareth Wilkins

# Client Information Sheet

**(all information is treated confidential)**

name:

date of birth:

address:

postcode:

phone numbers

home: business: mobile:

occupation:

email:

marital status: single / married / living with partner / separated / divorced / other

(please circle)

do you have any children? if so how many? what age range?

hobbies/recreation:

who were you referred by: GP name and address:

permission to contact GP? yes no

(please circle)

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please briefly describe the health problems you would like to resolve:

do you regard your health problem(s) to be:  severe / moderate / mild
(please circle)

what other forms of therapy have you used to resolve your health problem(s)?

how successful were they?  awesome / ok / rubbish
(please circle)

please list previous/other illness/accidents surgery that you have had:

please list any medication you are currently using:

in what way do you expect your health problems (s) to improve following these consultations:

over what period of time do you expect total recovery to occur?

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please list any supplements you are currently taking (vitamins, minerals, amino acids, anti-oxidants:

what is you intake of pure water? (not including fruit juice, soft drinks, herbal tea, tea, coffee)
(please circle) 2 litres / 1 litre / 500ml / Less

briefly describe your diet:

what are your favourite foods?

what are your bowel movements: daily / less than daily
(please circle)

how often do you exercise? daily / weekly/ occasionally run for the bus / never
(please circle)

on a scale of 1–10 what is your daily energy level?
Where do you want it to be?

do you sleep well? if not, why do you think this is?

do you smoke cigarettes? if so, how many per day?

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do you use orthotic appliances in your shoes?

do you experience back pain, neck pain or other physical pain?

if so where?

on a scale of 1 – 10 what is your pain level?

do you experience: ringing in the ears / clicking/popping of the jaw / facial pain?

have you had your wisdom teeth removed? if so was it all at once?

have you had other teeth removed? if so, was it for overcrowding?

is there any possibility you are or could be pregnant?
If yes, how advanced?

menstrual cycle: regular / irregular / painful / heavy / menopausal / other
(please circle)

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do you have breast or other implants?

please list any other concerns/comments regarding your symptoms/state of well-being, even if you feel they have no relevance to your current condition.

I declare that the information that I have given is correct and as far as I am aware I can undertake the treatment without any adverse effects. I have been fully informed about the contra-indications and I am therefore willing to proceed with the treatment.

signed: date: