



Client Consultation Form – *Diet and nutrition*

College Name:

Student Name:

College Number:

Student Number:

Client Name:

Date:

Address:

Sex: Male Female

.....

Profession:

Tel. No: Day..... Eve.....

GP Address:

PERSONAL DETAILS

Age group: Under 20 20–30 30–40 40–50 60+

Usual visit to Therapist:

Lifestyle: Active Sedentary

Last visit to the doctor:.....

No. Of children (if applicable):

Date of last period (if a applicable).....

WRITTEN PERMISSION REQUIRED BY:

GP/Specialist Client disclaimer

Either of which should be attached to the consultation form

PERSONAL INFORMATION;

Muscular/Skeletal problems: Aches/Pain Stiff joints Headaches Arthritis Rheumatism

Digestive problems: Liver/Gall bladder Stomach Constipation Diarrhoea Bloating IBS

Gastric ulcers

Circulation: Heart conditions Hypertension Hypotension Fluid retention cellulite

kidney problems Cold hands and feet Diabetes Hepatitis

Gynaecological: Irregular periods P.M.T Menopause H.R.T Pill Other

Nervous system: Migraine Tension Stress Depression M.E

Immune system: Prone to infections Sore throats Colds Chest Sinuses

Regular antibiotic/medication taken? Yes No If yes, which ones

Herbal remedies taken? Yes No If yes, which ones

Ability to relax: Good Moderate Poor

Sleep patterns: Good poor Average No. of hours.....

Do you see natural daylight in your workplace? Yes No

Do you work at a computer? Yes No If yes how many hours

Do you eat regular meals? Yes No

Do you eat in a hurry? Yes No

