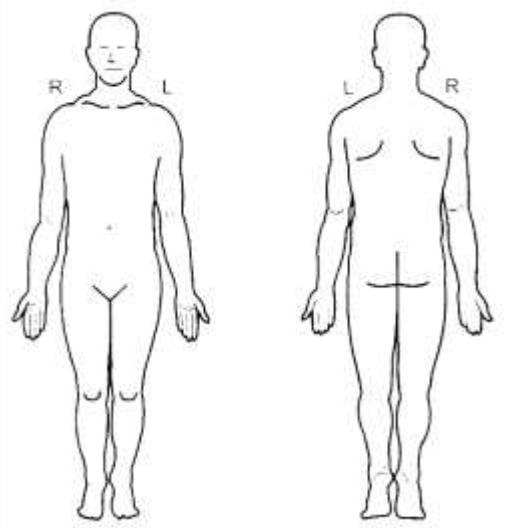
Kate Eldridge Bowen Therapy

MSc, BSc (Hons), BHS AI

Confidential New Client Consultation Form

PERSONAL DETAILS	
Name:	Date:
Address:	
Phone:	Mobile:
Email:	Date of Birth:

CONDITION REQUIRING TREATMENT	
Please describe your symptoms and how your daily life is affected: What do you think caused your condition? Doctors Diagnosis: Name/Address/Telephone number of GP/diagnosing Doctor: Are you taking any medications for this condition? (please state) Have you had any previous treatment for this condition from your Doctor or other healthcare practitioner?	

CONFIDENTIAL

MEDICAL HISTORY				
Have you had any of the following? (please tick all that apply)				
Headaches/Migraines	Fainting	Asthma	Allergies	Sinus problems
Ear problems	Dental Work	Breast Implants	Chills	Fever/Hot Flushes
Dizziness	Unexplained weight loss/gain	Indigestion/IBS	Orthotics	Unexplained tiredness
Mental Health problems	X-ray	Surgery	Accident (e.g. RTA, horse riding, boating)	

Have you had any other illnesses or health problems?				
Do you have children and/or are you pregnant?				
Is there a history of any of the following in your immediate family? (please tick all that apply)				
Diabetes	Heart Condition	High/Low Blood Pressure	Epilepsy	Cancer
Asthma/Allergies	Migraines	T.B	Other:	

Are you taking any other medications? (if so, please state)
How much water do you drink daily?
What is your normal sleep pattern?
What is your occupation and your main hobbies/sports/activities?
How did you find out about me?

I, the undersigned, have given Kate Eldridge accurate information regarding my past and present medical history and my general health and well being, and have agreed to treatment.

I agree to tell Kate about any changes to my health whilst I am receiving treatment from her.

I have been told about any responses that could occur during and after treatment, advised on post treatment care and have been made aware of any contra-indications to treatment by Kate.

I understand that there is a cancellation policy in operation and I will expect to pay the full fee of an appointment if I cancel without 24 hours notice.

Client's Signature:	Date:
Therapists signature:	Date: