Transform Your Health New Client Questionnaire

Title:	**First name:**	**Last name:**
Address:		
Post code:	**E-mail:**	
Telephone no. (Mobile):		**Telephone no. (Home):**
Occupation:		**Date of birth:** **Age**:
Your weight:		**Your height**:
GP Surgery Name & Address:		

Health Profile

What is your main reason for seeking nutritional advice?	
What outcome are you hoping to achieve?	

Please list any current health issues you are experiencing:

	Health Issue (e.g. arthritis)	**Management so far (e.g. GP, operation, exercise, paracetamol etc)**	**Onset Date**
1			
2			
3			
4			
5			

Have you had any other major surgery, biopsies, diagnosed medical conditions, significant periods of ill health or do you suffer from any chronic or niggling health problems or long term symptoms? (please give details e.g. high blood pressure, frequent colds, recurrent urinary infection etc).

Have you had any recent health tests?	Did you have any health issues as a child?
Are you awaiting any surgery or other medical procedures?	Have you used antibiotics recently or regularly in the past?
Have you ever reacted badly to any medication or vaccinations?	Are there any known health problems within the family?
Do you smoke? If yes how many a day and which variety?	Do you drink alcohol? If yes roughly how many units a week?

Questions for Women Only

Are you pregnant? If so, how many weeks?	Have you ever had a miscarriage?
Are you trying to become pregnant?	Which birth control method do you use, eg pill?
Are you post-menopausal?	Are you pre-menopausal?
Are your periods regular?	Do you have any symptoms leading up to or during your period?

Food/Digestion

Is there any food you dislike or avoid eating?	Is there any food that you crave?
Do you pass a stool on a daily basis?	Do you have any digestive symptoms (heartburn, wind etc)?

Additional questions

How did you find out about me?	
Are any other therapists/clinics involved in your care?	
Would you like to be emailed a quarterly newsletter?	Please mark one box: Yes ☐ No ☐

Client Medication Record

You are responsible for listing **all** prescription & over-the-counter medication, herbal medicine, or food supplements you are taking as this may affect the nutritional programme recommended. Please contact your therapist immediately if this changes.

Medication name	Dose	Frequency & duration	Condition being treated

Terms of Engagement

1. The degree of benefit obtainable from a consultation may vary between clients with similar health problems and following a similar programme.
2. The therapist is not permitted to diagnose, or claim to treat, medical conditions.
3. Standards of professional practice in Nutritional Therapy are governed by the BANT Code of Professional Practice.
4. The consultation may include aspects of nutritional therapy, kinesiology and reiki.
5. You are responsible for contacting your GP about any health concerns.
6. If you receive any treatment from your GP, or any other medical provider, you are responsible for telling them about the programme you are following and the supplements/pills you are taking.
7. It is important that you tell your therapist about any medical diagnosis, medication, herbal medicine, or food supplements, you are taking as this may affect the programme. Contact the therapist immediately if this changes during the programme.
8. If you are unclear or have any concerns about the agreed programme/food supplement doses/time period or how you are feeling, you should contact your therapist promptly for clarification.
9. You must contact your therapist should you wish to continue any specified programme for longer than the original agreed period, to avoid any potential adverse reactions.
10. Recording consultations using any form of electronic media is not allowed without the written permission of both the Therapist and the Client.

I understand the above and agree that our professional relationship will be based on the content of this document. I declare that all the information we share during this professional relationship is confidential and to the best of my knowledge, true and correct.

Client signature:		**Date:**	