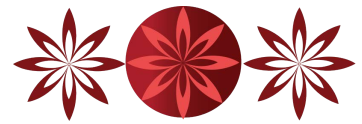
Client Intake/ History form



Dr./Mr./Mrs./Ms./Other______________________________

Surname__________________________________Given Name_____________________________

Preferred Name ____________________________

Work Ph__________________________________Home Ph _______________________________

Mobile Ph_________________________________Email__________________________________

Birth Date_________________________________Occupation____________________________

Emergency Contact__________________________Ph____________________________________

Regular doctor/Health Care Provider ____

Address____

Ph ____

How did you hear about us (please circle) : Family/ Friend/ Facebook/Gumtree/Google/ Instagram/Passing/Clinic Sign/Other_______________________________________

*** Allergies –** Medications/Food/Other____

____

____

____

____

____

____

____

Medications currently taking –____

____

____

____

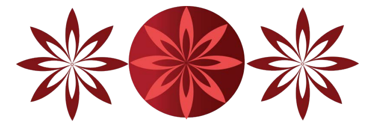
____

____

____

____

Client Consent for Treatment



Client Name (please print)____

There may be associated risk with any therapeutic intervention. Your careful responses to the questions asked in this client history, will assist us to ensure that any risks are minimised and the appropriate care is provided.

I understand that:

- This is a Nutritional Medicine clinic, NOT a medical practice.
- A consultation process reviewing my health history details is required before treatment begins.
- The practitioner will determine a therapeutic strategy that is appropriate for my needs and within the bounds of the practitioner's scope of practice.
- The practitioner will explain the proposed therapeutic strategy and treatment plan to me and my consent to this plan will be sought.
- Instructions about physical contact during treatment will be discussed.
- I can alter the treatment plan at any stage during treatment in conjunction with practitioner.
- At any time, I may choose to terminate further treatment.
- The physical examination I receive may involve partial undressing and may require the practitioner touch me.
- There may be risks of infection that occur between practitioners and their clients. These risks cannot be eliminated due to incubation periods that prevent people from knowing their infectious status.

Infection control strategies are in place to protect both clients and practitioners in this clinic.

If you have any other questions, please ask your practitioner.

DO NOT sign the following until your Practitioner has discussed your case and outlined your treatment program with you.

I understand that there are some risks with any form of care. I have discussed my risks with my Practitioner, have been given the opportunity to ask questions and I am satisfied with the answers.

I understand that I can choose to cease care at any time. Having discussed and understood the program of care outlined for me, I grant permission for care to proceed.

Signed (Client)______________________________________ **Date**_____________

Signed (Practitioner)_________________________________ **Date**_____________

* Do you suffer from any of the following?(tick appropriate boxes)

Limb pain/problems
☐arthritis
☐cramps
☐oesteoporosis
☐swelling________________
☐other__________________

Breathing/lungs
☐asthma
☐emphysema
☐sinus problems
☐allergies
☐other__________________
____

General
☐headache
☐dizziness
☐poor health
☐fainting
☐fatigue
☐tension/stress/anxiety
☐irritability/nervousness
☐sleeping problems
☐depression
☐loss of memory
☐convulsions/seizures

Skin conditions
☐rashes
☐itching
☐poor wound heaaling
☐dry skin/dermatitis
☐burisse easily
☐eczema
☐psoriasis

Heart
☐angina
☐chest pains
☐heart problems________________
☐pacemaker
☐blood pressure
____
☐blood clots/DVT- where___________________
☐stroke (CVA)

Digestion
☐abdominal
☐digestive problems
☐stomach upset
☐ulcers
☐constipation
☐diarrhoea

Other
☐diabetes mellitus
☐cancer/tumours
☐hepatitis B/C
☐AIDS/HIV
☐Epilepsy
☐Kidney

Females
☐menstrual problems / PMS
☐pregnant - how many months______________
☐ contraceptive use

Reason for seeking medicinal nutrition assistance

* Do you have a current concern/cause for assistance? Yes/No

____
____
____
____
____
____
____
____

Nutrishous 'n' Delicious

Past Medical History -

Family History -

____

____

____

____

____

____

____

____

____

____

____

____

*

Are there any foods that you cannot or, do not like to eat for personal/religious/health reasons? Please make a list with reasons

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

Observations:

BP__________Pulse_________Temp_______ Resps_____ Weight______Height______

General Comments

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____