THINKNUTRITION

CLIENT REGISTRATION FORM

Please complete this form as fully as possible.

First Name:			Your GP's Name:	
Surname:			Address:	
Address:				
Town/City:				
County:			Date of Birth:	
Postcode:			Age:	
Home Tel:			Height:	
Mobile Tel:			Weight:	
Work Tel:			Occupation:	
E mail:			Job Title:	
If above is a minor, please provide parents' details:			Is your job hectic/stressful?	
Mother:			Do you smoke?	
Father:			How did you hear about us?	

What are your health concerns and what would you like to achieve?

Is your GP aware of your health concerns? Do we have your permission to write to your GP?

Are you seeing any other Professional for any condition or treatment? If yes, please provide details

Do you take or are you about to take any prescribed or self prescribed drugs, medicines, supplements, remedies, etc.?

If yes please provide details & dose:

Have you had any serious illnesses or surgery in your life?

Have you taken antibiotics in the last 10 years or as a child?

Are you pregnant now or looking at fertility? Have you had a miscarriage?

Do you take a contraceptive pill, patch or device? Are you on HRT?

I hereby acknowledge that the above information is correct & will notify the clinic if my medical history changes and I agree to the clinic terms, charges & conditions.

Print Name:

Signature: **Date:**