Client Consultation Form

<table>
<tr><td colspan="2">Patient/client information</td></tr>
<tr><td>Full name:</td><td>Date of birth:</td></tr>
<tr><td colspan="2">Gender:</td></tr>
<tr><td>Contact information:
Phone number:
Email address:
Address:</td><td>Emergency contact:
Name:
Relationship:
Phone number:</td></tr>
<tr><td colspan="2">Medical history</td></tr>
<tr><td rowspan="2">Do you have any existing medical conditions?
☐ Yes No</td><td>If yes, please specify:</td></tr>
<tr><td></td></tr>
<tr><td rowspan="2">Are you currently taking any medications?
☐ Yes No</td><td>If yes, please list:</td></tr>
<tr><td></td></tr>
<tr><td rowspan="2">Do you have any allergies?
☐ Yes No</td><td>If yes please list:</td></tr>
<tr><td></td></tr>
<tr><td colspan="2">Consultation details</td></tr>
<tr><td colspan="2">What brings you in today?</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td rowspan="2">Have you had any previous treatments for this issue?
☐ Yes No</td><td>If yes, please explain:</td></tr>
<tr><td></td></tr>
<tr><td colspan="2">What are your goals for this consultation?</td></tr>
<tr><td colspan="2"></td></tr>
</table>

Lifestyle information	
Do you smoke? ☐ Yes No Occasionally	If yes, how many per day?
Do you consume alcohol? ☐ Yes No Occasionally	If yes, how many drinks per week?
What is your current exercise routine?	

Consent and agreement	
I hereby consent to the collection and use of my information for the purposes of my treatment. ☐ Yes No	
Signature:	**Date:**

Additional notes

Healthcare professional information	
Name:	**License ID:**
Signature:	**Date of consultation:**