Client Consultation Form

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

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:**