Client Consultation Form

Personal Information	
Name	
Date of birth	Gender
Address	
Phone number	Email
Medical history	
Name of primary care physician (if applicable)	
Do you have any chronic medical conditions (e.g., diabetes, hypertension, asthma)?	
Have you ever been diagnosed with any significant illnesses or conditions in the past?	
Have you undergone any surgeries or hospitalizations? If yes, please provide details and dates.	
List all the medications you are currently taking, including prescription, over-the-counter, and supplements.	
Do you have any known allergies to medications, foods, or environmental factors? If yes, please specify.	
Are there any significant medical conditions that run in your family? Please provide details.	

Health concerns
Reason for the consultation
Duration of the issue
Symptoms experienced
Any previous treatments tried
Lifestyle and habits
How often do you engage in physical activity or exercise? What type of exercise do you prefer?
Describe your typical daily diet, including any specific dietary preferences or restrictions.
How many hours of sleep do you usually get per night? Do you have any sleep-related issues?
Do you use tobacco, alcohol, or recreational drugs? If yes, please provide details.
Are there any hazards or exposures at your workplace that may be relevant to your health concern?
Psychological and Emotional Health
On a scale of 1 to 10, how would you rate your stress levels? (1 = low, 10 = high)
Have you experienced any significant life changes recently, such as job changes, relationship status, or relocation?

Are you currently experiencing any psychological or emotional concerns, such as anxiety or depression?	
Other information	
Are there any social factors or support systems that may impact your health concern?	
Is there any other information you would like to share that may be relevant to your health concern?	
Additional notes	
Acknowledgement	
I hereby confirm that the information provided above is accurate and complete to the best of my knowledge. I understand that this information will be used for the purpose of providing healthcare services. I consent to the use of this information in accordance with applicable privacy laws and regulations.	
Signature over printed name	**Date**