

Client Questionnaire

Name: _____

Address: _____

Email: _____

Contact No: _____

D.O.B: _____

Occupation: _____

Doctor: _____

(Please include name address and tel. No.)

Please tick this box if you are happy to receive my monthly e-newsletter with all my news and special offers

Please list your major complaints / symptoms in order of importance to you:

Complaint:	Since:	Causes (If known):
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently taking any medication / supplements? Please list

What operations have you had (if any) and when? any complications?

What major injuries have you had? (please include when and any long term effects)

How much of the following substances are you using per week?

Tobacco:_____ Alcohol:_____ Recreational Drugs:_____

Consent to Homeopathic treatment

I confirm that I request Homeopathic treatment from Cassie Everett at this clinic.

Signed: _____ Date: _____