

## Client Questionnaire

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Post code: \_\_\_\_\_

Email: \_\_\_\_\_

Home tel: \_\_\_\_\_ Mobile: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Doctor: \_\_\_\_\_  
(Please include GP's name, address and phone number)

Referred by: Recommendation / Website / Talk / Leaflet / Other \_\_\_\_\_

Tick box if you DO NOT wish to receive my monthly e-newsletter with news, self-help advice & special offers

Please list the complaints you would like to consult me about, in order of importance to you:

Complaint:	Since:	Cause (if known):
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any current medication, supplements and/or other treatment you are receiving:

\_\_\_\_\_

Please list any allergies or food intolerances (past and present):

\_\_\_\_\_

Please list any major injuries or operations you have had (including approx age/date):

\_\_\_\_\_

How much of the following substances do you use per week?

Tobacco: \_\_\_\_\_ Alcohol: \_\_\_\_\_ Recreational Drugs: \_\_\_\_\_

### Consent to Homeopathic Treatment

I confirm that I request homeopathic treatment from Cassie Everett and have received the Client Information.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

