Client Consultation Form

Jane Thomas ECBS / MBTER Date……

http://www.totallybowen.co.uk

First Name:
Last Name:
Email:
Address 1:
Address 2:
Town /City:
Post Code:
Country:
Phone Number:
Mobile Number:
Doctor / GP's Name:
Surgery Address 1:
Surgery Address 2:
Town / City:
Post Code:
Phone Number:

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Are you currently taking any dietary supplements? E.g. Vitamins Minerals etc
What is your daily intake of water? roughly
Do you eat a varied diet?
What are your favourite foods?
Do you eat fish/seafood?
Are you vegetarian or vegan?
How often do you exercise, and how?
How Active and motivated do you feel on a scale of one to ten?
Do you sleep well? If not do you know why?
Are your bowl movements daily / Less than daily?
Have you have and jaw reconstruction or major dentistry?
Have you ever worn orthodontic appliances?
Have you had a significant number of teeth removed?
Are you currently taking any prescribed medication or of the shelf drugs?
Does your menstrual cycle cause you concern?
Is there any possibility you could be pregnant?
Do you have breast implants?
Have you had breast surgery?

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Have you had any significant accidents & injuries, please describe and date?
Have you had any surgery, please describe and date?
Briefly describe the health problems you would like to resolve?
Have you used any other forms of therapy?
If so how successful where they?