

# Client Information Sheet

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

\_\_\_\_\_ Postcode: \_\_\_\_\_

Phone numbers: Home \_\_\_\_\_ Mobile: \_\_\_\_\_

e-mail: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: Single / Married / Living with Partner / Separated / Divorced/widowed

Do you have any children? \_\_\_\_\_ If so, how many? What ages? \_\_\_\_\_

Hobbies/Recreation: \_\_\_\_\_

Who were you referred by / How did you hear about me? \_\_\_\_\_

GP Name & Address: \_\_\_\_\_

\_\_\_\_\_ Permission to contact GP? YES NO

Please list any supplements that you are currently taking (Vitamins/minerals/amino acids/anti-oxidants): \_\_\_\_\_

What is your daily intake of pure water? (Do not include fruit juice/herbal tea/coffee)  
2 litres  1 Litre  500ml  Less

Briefly describe your diet: \_\_\_\_\_

What are your favourite foods? \_\_\_\_\_

Are your bowel movements: Daily  Less than Daily

How often do you exercise? Daily  Weekly  Occasionally  Never

On a scale of 1-10 what is your energy level? \_\_\_\_\_

Do you sleep well? \_\_\_\_ If no, why do you think this is? \_\_\_\_\_

Do you smoke cigarettes? \_\_\_\_\_ If so, how many per day? \_\_\_\_\_

Do you use orthotic appliances in your shoes? \_\_\_\_\_

Do you experience ringing in the ears, clicking/popping of jaw or facial pain? \_\_\_\_\_

Did you ever have jaw surgery? \_\_\_\_\_

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Have you had your wisdom teeth removed? \_\_\_ If so, was it all at once? \_\_\_\_\_

Have you had any other teeth removed? \_\_\_ If so, was this for overcrowding? \_\_\_\_\_

Did you ever wear orthodontic appliances? \_\_\_\_\_

Is there any possibility that you could be pregnant? \_\_\_ If yes, how advanced? \_\_\_\_\_

Menstrual Cycle: regular  irregular  painful  heavy  menopausal  other

Do you have breast implants? \_\_\_\_\_

Briefly describe the health problem(s) that you would like to resolve: \_\_\_\_\_

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Do you regard your health problem(s) to be: Severe  Moderate  Mild

What other forms of therapy have you used to resolve your health problem(s)?

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How successful were they? \_\_\_\_\_

Please list previous/other illness/accidents/surgery that you have had: \_\_\_\_\_

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Please list any medication you are currently using: \_\_\_\_\_

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Please consider carefully any other concerns/comments regarding your symptoms/state of well-being, even if you feel they have no relevance to your current condition and list them here: \_\_\_\_\_

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Signed

Date: