

Client Consultation Form

Martina Hinds ECBS
<http://martinahinds.com>

Date.....

First Name:
Last Name:
Email:
Address 1:
Address 2:
Town /City:
Post Code:
Country:
Phone Number:
Mobile Number:
<u>Doctor / GP's Name:</u>
Surgery Address 1:
Surgery Address 2:
Town / City:
Post Code:
Phone Number:
Do you wish your GP to be kept informed of your course of Bowen treatments? Yes..... No.....

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Are you currently taking any dietary supplements? E.g. Vitamins, Minerals etc...

Are you currently taking any prescribed medication? (please name and give dosage)

What is your daily intake of water? (Roughly e.g. 4 glasses)

Do you eat a varied diet?

How often do you exercise, and how?

How active and motivated do you feel on a scale of 1 to 10? (Scale 1 unable to be active to 10 being very active)

Do you sleep well?

If not do you know why?

Are your bowel movements daily / Less than daily?

Have you had jaw reconstruction or major dental work?

Have you ever worn orthodontic appliances?

Have you had a significant number of teeth removed?

Next 4 Questions - For Women Only:

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? (e.g. mastectomy or to remove lumps) Please describe and give dates.

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Have you had any significant accidents or injuries? Please describe and provide date.

Have you had any surgery? Please describe and provide date.

Briefly describe the health problems you would like to resolve? Beside each problem on a scale of 1 to 10 indicate how the problem affects your quality of life? (Scale: 1 doesn't affect.....10 very badly)

Have you used any other forms of therapy?

If so, how successful where they?

Please return your completed form ahead of your appointment via email to martina@martinahinds.com or post to: Martina Hinds, 10 Mount Pleasant, Houghton-Le-Spring, Tyne & Wear. DH5 8AQ