

NEW CLIENT FORM

Date: _____ Name: _____

Address: _____

Phone: _____ Email: _____

D/O/B: _____ Age: _____ Gender: _____

Relationship Status: _____

Occupation or past occupations: _____

Emergency contact person (Name, number & relation to you):

Are there any religious, cultural or other considerations I need to be aware of?

CLIENT CONSENT

I, _____ give consent for my health information to be documented and physical examinations performed. I understand that a treatment plan will be created for me by the practitioner (Francesca Eldridge).

I have given the practitioner all personal information needed to perform a safe and successful treatment, including disclosing all medications I am taking and whether I have recently become pregnant or intend to do so soon.

I am aware that both myself and the practitioner have the right to stop treatment at any time. I agree to disclose to the practitioner if I have an adverse response to any of the recommendations in my treatment plan. I understand that the practitioner is not providing medical care and is providing advice around diet, lifestyle and relevant diagnostic testing.

I have read and sign my agreement to the Terms and Conditions listed at the bottom of this web page: www.francescaeldridgehealth.com/bookings.html

Signature: _____ Date: _____

Practitioner name and signature: _____

Your health concerns and goals:

Please describe your health concerns:

When did they start?

What was happening around or just before the onset of your symptoms?

What do you feel are contributing causes?

Have you noticed if anything worsens or reduces your symptoms? (foods eaten, stress levels, caffeine, being around or not around certain people or environments?)

What are your medium-term health goals? And long term?

How strong is your motivation to make long-term changes to your diet and lifestyle for your health? What challenges might you have to overcome in making changes?

History:

Were you a vaginal or caesarean birth?

Were you breastfed? For how long?

Any injuries, accidents, hospitalizations or surgeries before age 20?

Any accidents, injuries, hospitalizations or surgeries from age 20 onwards?

Any history of skin conditions, allergies or asthma?

Have you travelled abroad - where and when?

Please list all past and current prescription medication use, including when taken, for how long and dosage? Please include all courses of antibiotics.

Have you received any vaccinations?

Do you have dental fillings? Which type?_____

Eliminations:

Please tick the type of stools you normally pass and state colour and frequency (e.g., dark brown / light brown / orange / green >> every morning, five times a day, every second day) .

The Bristol Stool Chart

Adapted from the Bristol Stool Scale (Heaton et al 1992)

| | | |
|--------|---|---|
| Type 1 |  | Separate hard lumps, like nuts (hard to pass) |
| Type 2 |  | Sausage-shaped but lumpy |
| Type 3 |  | Like a sausage but with cracks on its surface |
| Type 4 |  | Like a sausage or snake, smooth and soft |
| Type 5 |  | Soft blobs with clear cut edges (passed easily) |
| Type 6 |  | Fluffy pieces with ragged edges, mushy stool |
| Type 7 |  | Watery, no solid pieces. ENTIRELY LIQUID |

Poo notes:

Urine - how many times per day and colour? _____

Any urinary urgency or incontinence? _____

Sweat - at rest or when active? Noticeable smell? _____

Periods - how often, heavy or clotty, any PMS (cramps, tender breasts, headaches, migraines, acne....anything else?) Any mental health changes such as increased anxiety, increased crying, suicidal feelings or feelings of deep sadness?

Lifestyle, sleep and energy levels:

Describe your alcohol consumption - how many drinks per week and which type?

Do you smoke cigarettes? How many per day/week?

Do you take recreational drugs (now or in the past)? Which drugs and how often? Please mention if you mix tobacco with any marijuana smoked. Please note, there is no judgment from me and all information you provide remains strictly confidential.

Which brands of soap, shampoo, cosmetics, skin products and deodorant do you use on your body most days?

Do you fall asleep easily? _____

How many hours a night do you normally sleep? _____

Ever wake during the night? Please describe (timing, frequency)

Do you remember your dreams? (often, sometimes, never?)

Preferred exercise and frequency? _____

Do you ever:

- Wake feeling tired? Y / N (please describe)
- Have energy crashes? Y / N (please describe)
- Feel wired, and what time of day does this usually occur?

Describe: _____

Emotional health:

Have you experienced trauma (abuse, neglect, highly distressing events) as a child, teen or adult?

What causes stress in your daily life?

Do you have people you feel safe discussing your feelings with, who you can rely on for emotional support and a listening ear?

Family health:

Please briefly note any health conditions experienced by your:

- mother
- father
- siblings
- mother's parents
- father's parents

Thank you for taking the time to complete your new client form, this helps us maximize the time available for your first appointment.

All information you have provided will remain strictly confidential.

W: www.francescaeldridgehealth.com

E: info@francescaeldridgehealth.com