Clients Record Card

Name: ……………………………………………………… D.O.B:……………………………..

Address: ……………………………………………………………………………………………………

……………………………………………………………………………………………………

Post Code: ……………….........

Telephone Number:…………………………………………………………….Mobile Number:………………………………

Email Address:...Would you like to subscribe to our FREE Monthly Newsletter: Yes / No

Doctors Name:…………………………… Doctors Address..

Doctors Telephone Number:……………………………………………………………………………

Medical History/Likely Reactions...

Reasons for seeking Therapy Treatment..

Other Relevant Information..

Other Allopathic or complementary Treatment/Medication being used..

I have been made aware of what is involved with the chosen treatment Yes/No How did you find us:..

Signature...

Treatment.. Date……………………………