Example Consultation Sheet

Name:	Date of Birth:	
Address:		
Phone numbers – Home:	Mobile:	Email:
Occupation:		

Marital Status: Single / Married / Partner / Separated / Divorced / Widowed Do you have any children, if so how many and what ages?
Hobbies/Recreation:

Who were you referred by / How did you hear about me? GP Name & Address:

Briefly describe health problem(s) you have:				
Do you regard your health problem(s) to be: Severe		Moderate		Mild
What other forms of therapy have you used?				

Please list previous/other Diagnosis, Illness, Accidents, Broken Bones, Injuries, Surgeries & Falls that you have had:

Please list any medication you are currently using:

Client Information

Please list any supplements that you are currently taking (Vitamins/minerals etc):

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?

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/build ups in your shoes?

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

Did you ever have jaw surgery?

Have you had dental reconstruction/implants?

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/brace?

Ladies

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

Menstrual Cycle: regular irregular painful heavy menopausal post menopausal other:
Do you have breast implants:

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

Please read and then sign one of the following as applicable

I _____ confirm that I have understood the treatment I am about to receive and that the information I have given above is correct. I have been fully informed about contra-indications and I hereby confirm I am willing to proceed with treatment without confirmation from my own GP or Consultant

Signed: Date:

I _____ confirm that I have understood the treatment and given my medical history I would prefer to consult with my GP or Consultant prior to receiving treatment.

Signed: Date: