

ZEST NATURAL HEALTH CLIENT FORM



NAME: _____

ADDRESS: _____

MOBILE: _____

HM PHONE: _____

DOB: _____

SEX: _____

ETHNICITY: _____

OCCUPATION: _____

WK PHONE: _____

HEIGHT: _____

WEIGHT: _____

BP: _____

ZINC: _____

Who can I thank for referring you to my practice?

What are your main concerns regarding your health?

- | | | |
|---|-----|----|
| Has anyone in your family suffered from heart disease before the age of 60? | YES | NO |
| Are you on prescription medication? | YES | NO |
| Do you take any supplements or herbal remedies? | YES | NO |
| Have you been hospitalised OR had anaesthesia recently? | YES | NO |
| Have you given birth in the last 2 years? | YES | NO |
| Are you pregnant? | YES | NO |
| Do you have an annual flu vaccination? | YES | NO |
| Do you use any form of hormonal contraception? | YES | NO |

If YES to any of above, please provide details:

Do you have or have you had any of the following (please circle)

Heart condition	Hypertension	PCOS	Irritable Bowel Syndrome
Hypoglycemia	Hepatitis	Psoriasis	Inflammatory Bowel Disease
Epilepsy	Stomach Ulcer	Hernia	Dizziness or Fainting
Anemia	Osteoporosis	Arthritis	Asthma/Eczema
Allergies	Glandular Fever	Cancer	Liver / Kidney Condition
Varicose Veins	Thyroid disorders	Diabetes	Headaches / Migraines
Endometriosis	Depression/ Anxiety	Gout	Urinary Tract Infections
Memory loss	Skin rashes	Bronchitis	Nasal / Sinus Congestion

If YES to any of above, please provide details:

Do you smoke? If yes, how many per day?

Do you drink alcohol? If yes, how much per day?

Out of 10 (10 = highest) how would you rate your overall energy levels?

Stress:

Do you struggle with time management?	Y/N	Do you frequently lash out at others?	Y/N
Do you openly vent your frustrations socially?	Y/N	Do you often feel anxious?	Y/N
Do you over react easily?	Y/N	Do you feel you are always rushing around?	Y/N

Sleep:

How many hours sleep do you approximately get per night? _____

Do you struggle to get to sleep?	Y/N	Do you take sedatives to aid in sleep?	Y/N
Do you wake during the night?	Y/N		

Exercise:

Do you do more than 2 hours of exercise per week?	Y/N		
What type of exercise do you do?		How long do you typically do this for?	

Are there any other factors you think I should know about?

I recognise that by providing my practitioner with complete details of my health history, I am enabling them to regard all aspects of my health status in my treatment. By not disclosing vital information this may have an impact on the success of my treatment outcomes. All of my case details are confidential and will be treated as such by my practitioner.

Client:

Date:

Practitioner:

Date: