

Surname	Forename(s)	Title	Date of Birth dd/mm/yy	Adult
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Address: ..... Postcode: .....

Telephone, Home: ..... Mobile: ..... Work: .....

GP/Health Centre Address: ..... Phone: .....

E-mail address .....

***Please circle Y or N and insert a date, as appropriate, in the boxes below***

Do you suffer from Diabetes? <b>Y/N</b> Date:	Do you suffer from Epilepsy? <b>Y/N</b> Date:	Have you had Rheumatic Fever? <b>Y/N</b> Date:
Have you had glandular Fever? <b>Y/N</b> Date:	Have you had Meningitis? <b>Y/N</b> Date:	Have you had Polio? <b>Y/N</b> Date:

What medications are you taking, if any?

What other treatments have you most recently had, or are having? e.g. Physiotherapy, Osteopathy, Reflexology, Acupuncture

***If you suffer from any of the following, then tick the appropriate box, and add any details that you feel may be helpful. Leave the others blank.***

<input type="checkbox"/> Jaw pain, or "TMJ syndrome"	<input type="checkbox"/> Recent teeth extractions, or past orthodontic treatment
<input type="checkbox"/> Lack of Sleep	<input type="checkbox"/> High or Low Blood Pressure
<input type="checkbox"/> Vertigo or Travel Sickness	<input type="checkbox"/> Operation(s) for Sight Problems, e.g. for squint
<input type="checkbox"/> Anaemia	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Chest Pains or Palpitations	<input type="checkbox"/> Headaches or Migraines
<input type="checkbox"/> Dyslexia, Dyspraxia or Dysphasia	<input type="checkbox"/> Hearing Problems or Tinnitus
<input type="checkbox"/> Thrush	<input type="checkbox"/> Digestive Problems
<input type="checkbox"/> Nervous Tics or Tremors	<input type="checkbox"/> Regular Colds or Infections
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression
<input type="checkbox"/> Chronic Tiredness or Lethargy	<input type="checkbox"/> Poor Circulation
<input type="checkbox"/> Back Pain or Sciatica	<input type="checkbox"/> Neck or Arm or Shoulder Pain
<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Skin Problems, e.g. eczema	<input type="checkbox"/> Allergies

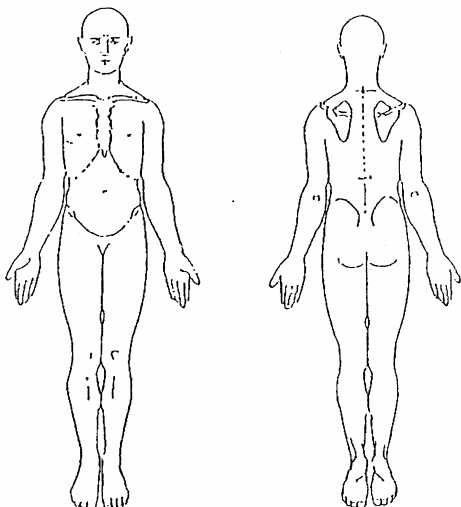
Please list all surgical operations and serious illnesses:

Please list any falls, or injuries, or accidents:

*Please indicate, in order of importance, the problems you would like help with:*

<b>1.</b>	<b>2.</b>
<b>3.</b>	<b>Any other comments?</b>

<b>Date of first Appointment:</b>	<b><u>Therapist Notes</u></b>
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**Patient Release, Cancellation, Consent to Treatment & Confidentiality**

I request and consent to treatments from Eric Demmon. I understand that my treatments may require the use of various hands-on approaches, including CranioSacral Therapy. I realise that the particular therapeutic outcomes of these treatments cannot be predicted with certainty and no guarantee can be made regarding any particular result or outcome.

I understand that my contact details will be held by Eric Demmon in data files, but will not made available to anyone else. I understand that I must give at least **24 hours notice to cancel an appointment**, or I may incur a £10 cancellation fee.

Signature..... Date: .....