Pre- Treatment and Medical History Form

Your Details

Name:	
Address:	
Email:	
Mobile:	
D.O.B.:	
GP Name:	
Address:	

When making your booking please advise me of any health conditions and all medication you are taking. For certain medical conditions I will require written permission from your doctor to proceed.

If you need to change or cancel an appointment, I ask that you give me 24 hours notice.

General Information
Please Complete All Questions

Are you breast-feeding?	Y / N
Do you have any allergies?	Y / N
Do you have liver / kidney problems, including kidney stones?	Y / N
Do you have heart disease, heart failure, or ever received treatment with cardiac stents?	Y / N
Are you diabetic?	Y / N
Are you taking anti biotics or had a recent infection?	Y / N
Are you taking any cancer or HIV medication? If Yes, please list the medication below	Y / N
Are you taking any anti-convulsant medication? If yes, please list the medication below	Y / N
Do you have a history of cardiac arrhythmias?	Y / N
Do you have a history of low potassium levels?	Y / N
Are you allergic to cobalt or sulfa?	Y / N
Do you have Lebers disease?	Y / N
Do you suffer from an iron deficiency?	Y / N
Do you have polycythemia vera?	Y / N
Do you have a history of gout?	Y / N
Do you have any dermatological issues such as rosacea?	Y / N
Are you taking chloramphenicol?	Y / N
Do you have a history of increased levels of iron absorption?	Y / N
Are you taking any of the following: fluphenazine / magnesium salicylate / mexiletine salsalate ?	Y / N
Please list any medication you are currently taking – either prescribed or over the counter below:	

Consent

I confirm that to the best of my knowledge that the information that I have supplied is correct and that there is no other medical information I need to disclose.

I understand that the use of treatments and products is not an exact science and therefore no guarantee can be given as to the results of the treatment referred to in this document or on this website.

I accept and understand that the goal of this treatment is improvement, not perfection, and that there is no guarantee that the anticipated results will be achieved.

Patient/Client Signature:	Date:
Practitioner Signature:	Date: