Client Information Sheet

Name:	Date of Birth:

Address:	Phone: Mobile: Occupation: Email:

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 and address:
Are you happy for me to contact your GP if necessary? YES / NO

Briefly describe health problem(s) you have:

Do you regard your health problem(s) to be: Severe ☐ Moderate ☐ Mild ☐

Please list previous illness, accidents, broken bones, injuries, surgeries & falls that you have had:

Please list any medication you are currently taking:

Are you undergoing any medical treatment at present?

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:

Do you have any allergies?:
How often do you exercise? Daily ☐ Weekly ☐ Occasionally ☐ Never ☐
On a scale of 1-10 what is your energy level?
How many hours do you sleep at night? Is this unbroken sleep?
Do you smoke? If so, how many per day?
Do you use orthotic appliances?
Do you experience ringing in the ears, clicking/popping of jaw or facial pain?
Have you ever had surgery on your jaw?
Have you had dental reconstruction/implants?
Have you had your wisdom teeth removed? Under General or local Anaesthetic?
Have you had any other teeth removed? If so, was this for overcrowding?
Have you ever worn orthodontic appliances/brace?

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

Menstrual Cycle: Regular ☐ Irregular ☐ Painful ☐ Heavy ☐ Menopausal ☐ Post-menopausal ☐
Other:

Have you had breast/chest implants?:

Do you have a pacemaker?

Do you or have you ever suffered with epilepsy?

Is there any other information that would be helpful regarding your treatment?

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.

Signature: Date:
I agree to my information being held by The Willow Clinic, for the purpose of my treatment.
Please Tick to give consent for us to hold this information on record ( )