Confidential consultation record

Name: _____ DOB: _____

Address: _____

Postcode: _____ Tel: Home: _____ Mob: _____

GP Name & Address: _____

_____ Tel: _____

Medical History

	YES	NO
1) Are you receiving treatment from a doctor, hospital or specialist	☐	☐
2) Are you or have you been taking medication from your doctor in the last six weeks?	☐	☐
3) Are you currently taking blood thinners or anti-coagulant medication?	☐	☐
4) Do you suffer from any of the following?		
☐ Allergies ☐ Eczema ☐ Hormonal Imbalance ☐ Rosacea ☐ Acne ☐ Heart Condition		
5) Do you have any other medical conditions?	☐	☐
6) Are you taking any herbal supplements?	☐	☐
7) Is there any possibility of pregnancy?	☐	☐
8) Are you breast feeding?	☐	☐
9) Do you suffer from any acute or chronic skin problems?	☐	☐
10) Have you ever had treatment for cancer?	☐	☐
11) Do you smoke?	☐	☐
12) How many units of alcohol do you consume in a week?	☐	☐
13) How often do you exercise?	☐	☐
14) Do you sleep at least 7.5 hours each evening?	☐	☐
15) Do you suffer from stress?	☐	☐
16) Do you live in the city?	☐	☐

Signed by the client _____ Signed by the practitioner _____

Please note this form is to assess your suitability to take one or more Rejuvenated supplements. Our supplements are totally natural but may interfere with some medications or may not be suitable when pregnant or breast feeding. Please give your practitioner all information that may be relevant.