CONFIDENTIAL CLIENT RECORD

Name

Date of Birth

Address

Email ___________________________________

Mobile___________________________________

Occupation

How did you find out about me?

G.P. Practice Name

Phone Number

Chief Complaint (describe fully)

Duration of condition? ____

What do you believe caused this condition?____

Have you had a Doctor's Diagnosis?

Any recent blood tests, x-rays or imaging?

Current Medical or Complementary Treatments Receiving

Allergies (including details of anaphylaxis and how the reaction was handled)

Please state if you have an EpiPen and bring it with you.

Previous Medical Conditions (including dates)

Injuries (any slips, falls, car accidents etc.)? ____

Any back complaints? ____

Which past illnesses have you had? ____

Any previous surgeries? ____

Surgical/Trauma Scars? ____

Medical Procedures? ____

Do you smoke? No Yes How many per day?_________ How many years?____________

Do you drink alcohol? No Yes How much?____

Do you take drugs? No Yes List names____

Do you take vitamins? No Yes List names____

Do you wear orthotics? No Yes Are they prescribed? _________Last Fitting?________________

Dental work? No Yes Details ____

Do you exercise? Regularly_____________Infrequently____________ Seldom______________

Are you pregnant? No Yes No. of Weeks_______ EDD_________ Last Period ___________

If you suffer from exhaustion or fatigue, describe in your own words how you feel and what time of day or night you experience these symptoms, including whether they occur daily, occasionally etc.

If you feel you are under a lot of stress, please explain.

Do you experience undue worry, difficulty in concentrating, forgetfulness, failing memory, etc.?

Female: Do you or, did you experience pain or discomfort before, during or after menstrual cycle? Do you suffer from PMT? Do you suffer from PCOS? Do you or, did you suffer from irregular cycles? Do you or, did you suffer from dysmenorrhoea? Specify other.

If you feel you are under a lot of stress, please explain.

Immunisations No Yes List names, dates and reactions

Childhood Illness

Measles ____________ Mumps _____________ Chicken Pox _____________ Rubella ____________

Unusual Childhood Diseases____

Direct Family Medical History

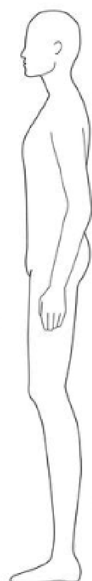
Mental Disease	No/Yes	Asthma	No/Yes	Heart Disease	No/Yes
Cancer	No/Yes	Lung Disease	No/Yes	Arthritis	No/Yes
Special Needs	No/Yes	Diabetes	No/Yes	Epilepsy	No/Yes
High/Low BP	No/Yes				
Allergies	No/Yes	List them________________________________			

Any Other (specify)____

Do you suffer from any of these symptoms: Only complete column **B**

B	A		B	A	
		Headaches			Excessive Gas
		Hot Flushes			Insomnia
		Blurred Vision			PMT
		Dizziness			Poor Memory
		Morning Fatigue			Sexual Impotency
		General Fatigue			Excessive Perspiration
		Laboured Breathing			Palpitation of the Chest
		Shortness of Breath			Dry Skin
		Indigestion			Poor Appetite
		Heartburn			Excessive Appetite
		Lump in the Throat			Night Sweats
		Throat Constriction			Nerves
		Numbness			Depression
		Fainting Spells			Learning Disabilities
		Light Headedness			Asthma
		Swelling of the Joints			Chemical Sensitivities
		Loose Stools			Constipation
		Candida			ADHD
		Arthritis			Pain Disorders

TO BE COMPLETED BY THE PRACTITIONER



Client Agreement

I.. [name]

- ☐ I understand that payment is due at the end of each treatment session by bank transfer, card payment or cash. The initial consultation appointment payment is £75 and follow-up appointments are £55 each. If a block of 3 treatments is booked, the cost is discounted to £150.
- ☐ I agree that if I cancel without 36 hours' notice or fail to attend, 50% of the appointment cost will become immediately due and payable through a payment link provided via WhatsApp.
- ☐ I confirm that I have provided accurate information about my medical history, health, and well-being to Amanda Philipe-Savage, and I consent to treatment.
- ☐ I will inform Amanda of any changes to my health during the course of treatment. I understand the potential responses and have been informed about any contraindications to treatment.
- ☐ I consent to my records being stored both digitally and manually, in accordance with GDPR. My data will be kept securely for 7 years after my last appointment and then disposed of. I agree to be contacted by Amanda via email, phone, or text and will be shown the full GDPR policy.
- ☐ I give permission for my anonymised medical history and treatment details to be used for research and education, including photos, lab results, x-rays, and measurement data.
- ☐ I understand that Amanda does not diagnose or cure any illnesses with treatments like Kinesiology, NAET, Bowen, Reiki, or other services.
- ☐ I acknowledge that treatments and tests do not diagnose diseases through conventional medical methods. Techniques like kinesiology and movement assessments indicate the best course of treatment.
- ☐ I agree to continue all prescribed medications and treatments unless directed otherwise by my prescribing doctor.
- ☐ I will follow all instructions provided, particularly for NAET, to avoid sensitivity reactions and ensure the treatment's effectiveness. I understand that follow-up procedures may be necessary.
- ☐ I will disclose any history of anaphylaxis (sensitivity reactions) before starting treatment to ensure allergens are avoided.

You may freely ask questions about this form or the treatment, now or at any time during your treatment. If you experience any after-effects or have any questions about your treatments, you may contact your practitioner, Amanda Philipe-Savage by email, phone or text.

I have read/*had read* to me the above statements and have had the opportunity to consider the information and ask questions. Procedures and follow-up actions have been described. I understand that if I am anaphylactic, I must attend with a surrogate when receiving NAET, and that treatments will be performed through them. By signing below, I agree to the terms and conditions and take full responsibility for accepting the treatment and outcome.

______________________	______________________	______________
Patient Signature	Print Name of Patient	Date
______________________	______________________	______________
Guardian Signature	Print Name of Guardian	Date