‘BELLIES & BUBS’
CLIENT INFORMATION/HEALTH FORM

NAME:____
ADDRESS:____
EMAIL:________________________________MOB:____________________
OCCUPATION:__________________________ D.O.B:________________
MARITAL STATUS:………………………HEALTH FUND (ANCILLARY):__________
SPORTS/ACTIVITIES/HOBBIES:___________________________________

PLEASE PROVIDE INFORMATION ON THE FOLLOWING:-

Illness/Injuries/Accidents____
Spinal Disorders____
Infection/Contagious Diseases____
Allergies ____
Operations (includes C-Section) ____
Heart or Circulation Disorders (Varicose Veins, DVT, Vulval Varicosities (if pregnant)
____
Previous pregnancies/miscarriages ____

DO YOU SUFFER FROM:
Headaches/Pain/Numbness____
(When not pregnant) Period Pain/Menstrual Cycle information______________________

ARE YOU CURRENTLY:
On medication/natural supplements____
Having other Treatment (Chiro/Physio/Acupuncture) ____________________________

ARE YOU PREGNANT ?
How many weeks? _________________
If 28+wks do you have Gestational Diabetes (dietary managed/insulin dependant) or Pregnancy Induced Hypertension (high blood pressure) is your baby malpositioned - breech/transverse/posterior (please circle)?

WHAT ARE YOUR MAIN CONCERNS TODAY? ______________________________

SIGNED:…………………………………………………… DATED: ……………………………………….