## Enjoy Nutrition

# CLIENT REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| |  |  | | --- | --- | | Date: [Date] | Practitioner: Tracy Thompson |  PATIENT INFORMATION  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Last name: | First: | Middle: | Title: |  | Marital status: |  |  |  |  | | --- | --- | --- | | Birth date: | Age: | Sex: |   Address:   |  |  |  |  | | --- | --- | --- | --- | | Home phone no.: | Mobile phone no.: | | | | Email: | | Occupation: | | If you are you happy to receive email updates/news/tips from our practice: PLEASE TICK ⃝ | |  |  |  | | --- | | Are you a Healthcare or Pension Card Holder : YES / NO  (Card Number: ) | | Chose clinic because/referred to clinic by: |  | | Have you seen a Nutritionist or Dietitian previously? YES / NO |  |  | | Other family members seen here: [Other patients] |  |  | | Health Information |  | | Smoker: YES / NO |  |  | | Your Nutrition Goals: (your top 3) 1. |  |  | | 2. |  |  | | 3. |  |  | | Allergies/Intolerances: |  |  | |  |  |  | |  |  |  | | Current Health Concerns: |  |  | |  |  |  | |  |  |  | | Medical History: |  |  | |  |  |  | |  |  |  | | Medications: |  |  | | Supplements: |  |  | |  |  |  | | Family Medical History: |  |  | |  |  |  | |  |  |  | | Weight History: |  |  | |  |  |  | |  |  |  | | Current Emotional State: |  |  | |  |  |  | | Current Sleeping Pattern: |  |  | |  |  |  |  IN CASE OF EMERGENCY  |  |  |  |  | | --- | --- | --- | --- | | Name of local friend or relative  (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.: | |  |  |  |  |   The above information is true to the best of my knowledge. I understand that I am financially responsible for my consultation.   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  | |  | Patient/Guardian signature |  | Date |  | |

**\*Please bring copies of your latest or relevant blood/pathology tests to each of your appointments.**