## 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 |  |

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