HOLISTIC SKIN CLINIC

CLIENT REGISTRATION FORM

Thank you for filling out this form. This form enables your practitioner to gather key information about your health history, enabling us to utilise the best of our time in clinic.

Full Name

Email

Date of Birth

Address

Phone number

How did you hear about us?

○ Internet Search ○ Event ○ Advertising ○ GP ○ Healthcare Provider
○ Family ○ Friend ○ Other

Number Of Children

Current Occupation

Past Occupation

SKIN CONDITION

If known, please state your skin condition

Has your skin condition been diagnosed by a dermatologist, GP (or other – please specify)?

Are you currently being treated by a dermatologist?

How long have you had your skin condition for?

Are you aware of any triggers?

Does anything make it better?

Is your skin:

○ Itchy ○ Dry ○ Weepy ○ Flaky ○ Painful ○ Hot

Please highlight the part of your body your skin condition is affected:

- ◯ Face
- ◯ Neck
- ◯ Shoulder
- ◯ Upper Back
- ◯ Lower Back
- ◯ Stomach
- ◯ Palms
- ◯ Toenails
- ◯ Finger Nails
- ◯ Scalp
- ◯ Feet
- ◯ Inner Arms
- ◯ Groin
- ◯ Thigh
- ◯ Knees
- ◯ Lower Legs
- ◯ Upper Legs
- ◯ Ears
- ◯ Elbows
- ◯ Backs of Arms
- ◯ Hips
- ◯ Bottom
- ◯ Soles of Feet
- ◯ Calves
- ◯ Back of Hands
- ◯ Other

MEDICATION

Please specify any medication you are currently taking, including over the counter medication eg. Panadol

Medication		Time taken for		Dose	
Medication		Time taken for		Dose	
Medication		Time taken for		Dose	
Medication		Time taken for		Dose	
Medication		Time taken for		Dose	

Please specify any supplements you are currently taking?

Do you have any allergies to any medication or supplements?

HEALTH CONDITIONS

Do you have any of the following:

- ◯ Cancer/Tumors
- ◯ Cysts
- ◯ Eye Disease / Disorders
- ◯ Asthma/Lung Complaints
- ◯ Liver Disease/Hepatitis A,B or C
- ◯ Diabetes 1 or 2
- ◯ Stomach Complaints (e.g. reflux, bloating, pain)
- ◯ Ulcers
- ◯ Gallstones
- ◯ Bladder/Urinary Disease
- ◯ Kidney Disease
- ◯ Thyroid Disease
- ◯ Hernia
- ◯ Appendicitis
- ◯ Rheumatic Fever
- ◯ Bowel/Intestinal Disease
- ◯ Skin Conditions
- ◯ Arthritis/Rheumatism
- ◯ Gout
- ◯ Snoring
- ◯ Night Sweats
- ◯ Anaemia
- ◯ Anxiety/Depression
- ◯ Glandular Fever
- ◯ Persistent or Frequent Colds/Flu
- ◯ Chronic Fatigue
- ◯ Varicose Veins

- ◯ Cardiovascular Conditions (Chest pain, high blood pressure)
- ◯ HIV/AIDS
- ◯ Malaria
- ◯ Food Poisoning
- ◯ Parasitic Infections
- ◯ Cold Sores
- ◯ Thrush
- ◯ Candida
- ◯ Shingles
- ◯ Warts
- ◯ Epilepsy
- ◯ Headaches
- ◯ Difficulty Sleeping
- ◯ Back/Neck Problems
- ◯ Major Head Injury/Car Accident
- ◯ Sexually Transmitted Diseases
- ◯ None of the above

FOOD

How would you rate your appetite?

◯ Low ◯ Good ◯ Excessive

Please note down your exercise regime below (type, frequency and duration per week)

How much water do you drink daily?

Do you drink tea / coffee / fruit juices?

◯ Yes ◯ No

Do you drink tap water?

◯ Yes ◯ No

Please list any foods you may have an intolerance to:

Please list any foods you actively avoid:

Please list any foods you crave:

What does your diet typically include?

Breakfast

Lunch

Dinner

Snacks

Please add any additional comments below that may with worth mentioning.

Please attach any recent photos (if you have) of your skin condition.