Patient No:

Vit B12 * Consultation Form

PERSONAL INFORMATION:

DATE:

FIRST NAME

LAST NAME

ADDRESS

CITY

POSTCODE

DATE OF BIRTH

COUNTY

PHONE

HEIGHT [CM]

WEIGHT [KG]

EMAIL

◯ YES ◯ NO

(Your email address will be used for appointment confirmations, and quarterly newsletters)
If you would like to subscribe to our newsletter and promotions please select YES or NOT

HOW DID YOU HEAR ABOUT US?

◯ WORD OF MOUTH ◯ LEAFLET ◯ INTERNET ◯ OTHER

For your client records, do we have permission to take before and after photographs?

◯ YES ◯ NO

MEDICAL HISTORY

Do you suffer from any of the following diseases?
[Please check all of the boxes that apply.]

- ◯ Leber's Disease
- ◯ Kidney Disease
- ◯ Liver Disease
- ◯ Iron Deficiency
- ◯ Recent Infection
- ◯ Folic Acid Deficiency
- ◯ Treatment/Medication Affecting Bone Marrow

If your answer is "Yes", please describe details:

Have you ever had an allergic/intolerances any reaction?

- ◯ Yes
- ◯ No

If your answer is "Yes", please describe details:

◯ I hereby give permission to perform this and all subsequent Vitamin B12 treatments.

Signature of the Patient

DATE: