Dorothy Kelly Fertility Consultation form

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| **Name:** | **DOB:** |
| **Address:** | **GP:** |
| **Tel:** | **Email:** |
| **Your weight:** | **Semen Analysis performed Yes / No****Result:****Has SA been banked? Yes / No****Follow up treatment? Yes / No****Have you had any DNA Fragmentation performed?****Yes / No** |
| **Do you smoke:** |
| **Occupation:**  |
| **Units of alcohol taken weekly:** |
|  **Any Urological problems?****Yes / No****If yes, please state:** | **Any sexually transmitted infections?****Yes / No** |
| **Have you conceived naturally before?****Yes / No** | **STIs/Mumps****Yes / No** |
| **Do you have children?****Yes / No** | **Length of time trying for a baby?** |
| **Stress levels 1 - 10,****10 worst, lowest 1. \_\_\_\_\_\_\_** | **How do you relax:****Exercise y / n Walking y /n reading y / n** |
| **Any other relevant medical history including recent surgery?** |
| **Any ongoing Investigations?** |
| **Any medication or supplementation:** | **Dietary habits:****Water intake daily:**  |

I confirm to the best of my knowledge the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment. The treatment

I am about to receive has been explained to me and I give my consent to reflexology. Under GDPR this information will be retained securely by me and will be held for 8 years as per recommendations of my insurance company.

**Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**