

**MSc Nutritional Therapy Teaching Clinic**

**NUTRITIONAL THERAPY CLINIC CLIENT CONTACT SHEET**

**PRIVATE AND CONFIDENTIAL**

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| **Date** |  |

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| --- | --- | --- | --- |
| **First Name:** | **Surname:** | | **Title:** |
|  |  | |  |
| **Address:** | | | |
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| **Telephone Numbers** | | **Email** | |
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| **Preferred Method and Time of Contact** | |
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| ***IF YOU ARE UNDER 18 YOU WILL NEED CONSENT FROM A PARENT OR GUARDIAN TO SEE A NUTRITIONAL THERAPIST*** | | | |
| **Name of Parent / Guardian:**  **Parent / Guardian Signature: ……………………………………………………. Date …………………** | | | |
| **name and address of gp**  (*Your GP will not be contacted without your written consent.*) | | | |
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| **Please return questionnaire to:** | | | |
| **Clinic Administrator**  **McClelland Centre, University of Worcester**  **Castle Street**  **WR1 3AS**  [nutritionaltherapyclinic**@worc.ac.uk**](mailto:nutritionaltherapyclinic@worc.ac.uk)**, 01905 54 2453** | | | |