CLIENT HISTORY

Personal Details

Name: Mr/Mrs/Ms/Miss/Master_____

Date of Birth: _____ Age: _____

Address: _____

Phone No: H_____W_____Mb_____

Email: _____

Occupation: _____

Next of Kin: _____ Ph: _____

*Spouse/Partner:*_____

Health Fund: _____

Present History

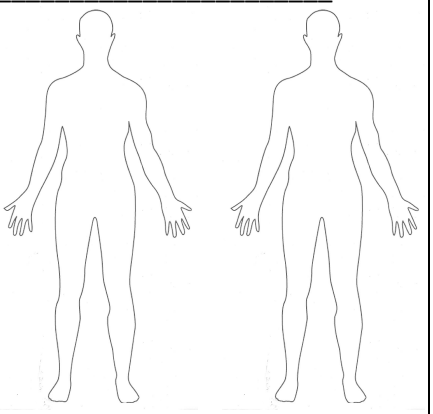
Reason for visit: _____

_____

_____

Pain: Yes/No ….Where? _____

(Please mark areas of pain on diagram with an 'x')



FRONT BACK

Nature of Pain: _____

Frequency: _____

Onset: _____

Relief: _____

Aggravation: _____

BODY SYSTEMS

(please circle for present condition, underline for past conditions & an 'x' next to, if you have or are seeing your GP)

RESPIRATORY

Asthma	Bronchitis	Pneumonia	Emphysema	Hay Fever
Chest breather	Tummy breather	Difficulty breathing	Smoker	Bronchitis
Cough	Persistent cough	Shortness of breath	Tuberculosis	Itchy eyes
Depression	Memory concerns			

Other respiratory concerns: _____

DIGESTION

Heart burn/reflux	Bloating	Constipation	Diarrhoea	Nausea
Ulcers	Abdominal pain	Slow eater	Fast eater	Flatulence/wind
Fatigue	Irritable bowel	Sinus	Skin disorders	Changes in appetite
Liver disease	Gallstones	Hiatal Hernia	Allergies	Headaches
Sugar cravings	Diabetes	Dehydration	Anxiety	Haemorrhoids
Pimples	Eczema/Hives			

Other Digestion concerns: _____

CIRCULATION

Cold hands/feet	Varicose veins	High blood pressure	Low blood pressure	Heart disease
Cholesterol	Anaemia	Swollen ankles	Chest pain	Low energy
Pins & Needles	Fainting	Heart attack	Pacemaker	

Other Circulatory concerns: _____

IMMUNITY

Rheumatic fever	Slow healing	Chronic infections	Chronic Fatigue	Ross River
Glandular Fever	Viruses	Candida	Colds/Flu	Auto-Immune
Rheumatic arthritis	Warts	Tonsillitis	H.I.V	Herpes
Hepatitis	Athlete's foot	Tuberculosis	Yeast infection	Sinus infection
Food allergies	Asthma	Environmental allergies	Auto-Immune disorders	

Other Immune concerns: _____

MUSCULOSKELETAL

Neck pain	Shoulder pain	Muscle cramps	Sciatica	Jaw clenching
Upper back pain	Mid back pain	Low back pain	Joint pain	Osteoarthritis
Clicking joints	Degenerative discs	Limited movement	Numbness	Tingling
Muscle soreness	Headaches	Fatigue	Rounded shoulders	Head injury
Jaw pain				

Other Musculoskeletal concerns: _____

FEMALE REPRODUCTIVE

Irregular cycles	Clotting	Heavy flow	Painful periods	Breast tenderness
Mood swings	Emotional outbursts	Headaches	Tension	Restless sleep
Menstrual cramping	Hot flushes	Sadness	Bleeding between cycles	
Depression	Foggy head	Stress	Weight Fluctuation	Libido changes
Lower back pain	Leg pain	Painful breasts		

Are you pregnant? Yes/No _____

Other Reproductive concerns: _____

ENERGY

Fatigue	Lethargic	Exhaustion	Frustration	Mood swings
Depression	Sluggish	Irritability	Anger	Concentration
Tension	Argumentative	Stuck	Buzzing	On alert
Difficulty sitting still	Fidgety	Huff'n'Puff	Short fuse	Regularly yell
Regularly critique	Energy fluctuations	Hunched posture	Use hands to hold head up	
Overwhelmed	Confusion	Lack of motivation	Walk with head down	
Hypothyroidism	Hyperthyroidism			

Other energy concerns: _____

NEUROLOGICAL/EMOTION

ADD	Impulsive	Learning difficulties	Restless	Shallow Breath
ADHD	Anorexia	Bulimia	Frustrated	Memory concerns
Anxiety	Stress	Tension	Epilepsy/Seizures	Stroke
Headache	Alzheimer's	Migraine	Emotional outbursts	Isolation
Boils	Depression	Nervousness	Mood swings	Vertigo
Dizziness	Loss of Balance	Eczema/Hives		

OTHER

Cancer — If so; please provide further detail:_____
_____

Hospitalisation — If so; please provide further detail: _____
_____

Other — Please provide further detail:_____
_____

LIFESTYLE

Vegetarian Vegan Lactose Free Wheat Free Smoker
Alcohol: If circled please provide details of type and quantity p/day:_____
Caffeine: If circled please provide details of quantity p/day:_____

NUTRITIONAL SUPPLEMENTS: Type:_____ For what purpose:_____
Type:_____ For what purpose:_____

MEDICATIONS: Type:_____ For what purpose:_____
Type:_____ For what purpose:_____

PREVIOUS ACCIDENTS (e.g. vehicle, falls)
Injury:_____
Age:_____

Injury:_____
Age:_____

TRAUMA (E.G: Braces, fillings, root canals, broken bones, fractures, dislocation, burns, whiplash, sexual abuse, vaccinations, violence, bullying, separations, nightmares, jammed fingers, house fire/bush fire threat, sprains, operations, death (family/friend/relative/pet))

Trauma:_____
Age:_____

Trauma:_____
Age:_____

BLOOD TYPE (*Please circle)* O A B AB

YOUR BIRTH
Natural YES/NO Caesarean YES/NO Forceps YES/NO
Premature YES/NO *If so,* how many weeks early: _____
Breech YES/NO Induced YES/NO
Difficulties YES/NO *If so, explain:* _____
_____

GENERAL
Are you seeing or under the care of other health professionals:

- G.P YES/NO _____
- Specialist YES/NO _____
- Naturopath YES/NO _____
- Chiropractor YES/NO _____
- Osteopath YES/NO _____
- Reflexologist YES/NO _____
- P.T. YES/NO _____
- Herbalist YES/NO _____
- Acupuncturist YES/NO _____
- Dietician YES/NO _____
- Masseur YES/NO _____

Have you had Kinesiology before: YES/NO _____

How did you find out about me: _____

What do you hope to achieve from Kinesiology? _____

_____

INTERESTS: _____

NEWSLETTER (Our Newsletter contains relatable topical information with valuable handy tips)

Would you like to receive our Newsletter: YES/NO

WRITE ANY ADDITIONAL INFORMATION HERE: _____

_____

PLEASE READ CAREFULLY BEFORE SIGNING:

I understand that payment is due at the time of treatment unless other arrangements have been made prior to the session. I agree to give at least 24 hours advance notice should I need to cancel an appointment.

I understand that the Kinesiology work, techniques, advice, take home material and all parts therein is to provide information and guidance towards whole body healing. I acknowledge that the work done within Kinesiology can take time. If I experience any pain, discomfort of any kind during the session, I will inform the practitioner immediately. I understand that Kinesiologists do not diagnose any disease, illness or prescribe. I confirm that I have stated all my known medical conditions and answered all questions honestly. I agree that it is my responsibility to inform the practitioner of any future changes in my health including disease, illnesses or medications to update my medical profile.

_____ _____

Client Signature Date

_____ _____

Practitioner Signature Date