KINESIOLOGY CLIENT HISTORY FORM

NAME:	PHONE/EMAIL:
ADDRESS:	DATE OF BIRTH:
OCCUPATION/YEAR AT SCHOOL	EXERCISE/HOBBIES/INTERESTS:
REFERRED BY:	EMERGENCY CONTACT NAME & NUMBER:

PLEASE GIVE DETAILS ON THE FOLLOWING:

WHAT IS THE REASON FOR YOUR VISIT IN ORDER OF IMPORTANCE? RATE IMPACT ON LIFE ON A SCALE OF 1-10

HAVE YOU SEEN ANYONE ELSE FOR THIS? If so who and how did you respond?	ARE YOU TAKING ANY MEDICATIONS/SUPPLEMENTS?

HAVE YOU HAD ANY HOSPITALISATIONS/MAJOR ACCIDENTS/ILLNESSES/INJURIES AND WHEN?

DO YOU HAVE/HAVE HAD ANY ALLERGIES?	CURRENT DIET/FLUID INTAKE:
HAVE YOU EVER SMOKED/CURRENT SMOKER?	DO YOU DO REGULAR MEDIATION/RELAXATION?

IS THERE A FAMILY HISTORY OF ANY MEDICAL OR GENETIC CONDITON?

CLIENT/GUARDIAN CONSENT FOR KINESIOLOGY HEALTH CARE:

To the best of my knowledge I have disclosed all information regarding my past and present state of health to enhance the Kinesiologist's ability to assist positive results.

I understand that Kinesiology is a complementary therapy and is not a replacement for medical care when necessary and that results are not guaranteed.

I acknowledge that the Kinesiologist adheres to best practice policies and that all information provided or exchanged during consultations follows the current Privacy Act as required by Law.

NAME: PARENT/GURADIAN:	SIGNATURE:	DATE:

***PLEASE TURN OVER TO FILL OUT TABLE**

PLEASE TICK ANY OF THE FOLLOWING ISSUES WHICH RELATE TO YOU AND DOUBLE TICK THOSE YOU WISH TO ADDRESS SPECIFICALLY					
Arthritis		Anger		Addiction	
Dizziness		Anxiety		Alcohol Use	
Bed wetting		Concentration		Career Choices	
Blood pressure issues		Depressed Feelings		Communication issues	
Bowel issues		Energy		Divorce	
Cancer		Fears		Drug Use	
Chronic Fatigue Syndrome		Fatigue		Dysfunctional behaviour patterns	
Depression		Grief		Education	
Diabetes		Guilt		Friends/Social	
Epilepsy		Inferiority		Family dynamics	
Headaches		Loneliness		Parenting issues	
Infertility		Memory		Relationships issues	
Insomnia		Motivation		Weight issues/Emotional eating	
Joint pain		Nervousness			
Nightmares		Regrets			
Pain		Sadness			
PMS		Sexual Problems			
Sleep apnoea		Self-Control			
Tinnitus		Shyness			
		Stress			
		Self Esteem issues			
		Self-sabotage			
		Temper			
		Trust			
		Unpleasant Thoughts			

PLEASE RATE THE FOLLOWING: (10 being excellent, 1 being poor)		
ENERGY LEVELS:	**LIVING SITUATION**	**WORK SITUATION**

ANY OTHER RELEVANT INFORMATION: