CLIENT INFORMATION SHEET

PERSONAL DETAILS

Title: _____ First Name: _____ Last Name: _____

Address: _____

Suburb: _____ P/code: _____

Email Address: _____

Mobile: _____ Have you had Kinesiology before? Yes / No

Introduced By?: _____ _____

What other forms of therapy have you used/or using to resolve your health problem(s)?

☐ Acupuncture ☐ Chiropractic ☐ Naturopathy ☐ Physiotherapy

☐ Chinese Doctor ☐ Doctor ☐ Massage ☐ Other: _____

DOB: _____ Age: _____ Sex: M / F

Single / Partner / Defacto / Married / Separated / Divorced / Widowed / Other: _____

Spouse/Partner (name, age): _____

No. of Children: _____ Ages: _____ Names: _____

The following information is gathered to assist understanding the client's overall life situation and background, and used to obtain greater depth during the Kinesiology balance, treatment and healing process.

FAMILY DETAILS AND HISTORY

Siblings? Yes / No Names & ages: _____

Are your parents: Together / Separated (when: _____) / Re-partnered / Passed away

How would you describe your relationship with each of your parents? *(write below)*

Mum: _____ Dad: _____

WORK / STUDY / OCCUPATION DETAILS

Occupation: _____

Do you enjoy your work? Yes / No Is your work stressful? Yes / No How? _____

LIFESTYLE FACTORS

What is your current energy level? (0 = no energy / 10 = most energy) _____

My stress levels at the moment are: High / Medium / Low

My current living situation is: Excellent / Good / Not Good / Poor Why? _____

How many hours do you sleep each night? _____ Sleep at _____ Wake at _____

Do you have trouble falling asleep? Yes / No If so, how long does it take? _____

Do you wake during the night? Yes / No If so, how many times? _____ What time? _____

Do you exercise? Daily / Twice or more weekly / Weekly / Fortnightly / Occasional / Never

What sort of exercise do you do and for how long: _____

_____

Relaxation or Meditation: Daily / 2-3 x a week / Weekly / Fortnightly / Occasional / Never

EMOTIONAL & PHYSICAL HEALTH INFORMATION AND HISTORY

Please tick any of the following items that you can relate to as a stress, may experience, feel at present or have suffered, in the past:

- ☐ Allergies (hayfever / food / substance)
- ☐ Anger issues
- ☐ Anxiety / Nervousness
- ☐ Back pain (low / middle / upper)
- ☐ Cancer
- ☐ Children / Parenting stress
- ☐ Communication problems
- ☐ Concentration issues
- ☐ Constipation
- ☐ Decision making difficulty
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhoea
- ☐ Digestive problems
- ☐ Divorce / Separation stress
- ☐ Dizziness
- ☐ Drug use
- ☐ Education / study stress
- ☐ Fatigue / Tiredness
- ☐ Fear (of _____)
- ☐ Financial stress
- ☐ Friend problems
- ☐ Grief (of _____)
- ☐ Guilt (around _____)
- ☐ Headaches
- ☐ Heart problems
- ☐ High / low blood pressure
- ☐ Incontinence
- ☐ Insomnia
- ☐ Jaw pain or clicking / TMJ
- ☐ Kidney pain / ailment
- ☐ Lack of energy
- ☐ Legal matters stress
- ☐ Loneliness
- ☐ Relationship difficulties
- ☐ Memory recall
- ☐ Migraines
- ☐ Motivation lacking
- ☐ Muscle cramps / spasms
- ☐ Neck pain / tension
- ☐ Poor circulation
- ☐ Regret (of _____)
- ☐ Regular colds & flus
- ☐ Relaxation difficulty
- ☐ Repetitive thoughts or memories
- ☐ Self-control (with _____)
- ☐ Self-esteem issues
- ☐ Sexual problems
- ☐ Shyness / Timidity
- ☐ Skin problems (acne / psoriasis / eczema)
- ☐ Sleeping problems
- ☐ Suicidal thoughts
- ☐ Temper control
- ☐ Trust issues
- ☐ Unhappiness
- ☐ Weight trouble
- ☐ Work related stress
- ☐ Other mental / emotional / physical health concerns: _____

_____

_____

_____

From the list above, please list any items you would specifically like to work on:

_____

_____

_____

FEMALE SECTION

Are you pregnant? Yes / No If yes, please specify due date _____

Cycle duration? _____ days Do you suffer from menstrual problems? Yes / No

Describe your cycle (circle): Regular / Irregular / Heavy / Painful / Menopausal / Other

Are you currently on the contraceptive pill? Yes/No Pill / Mini-Pill / Implanon / Mirena / Patch

Are you trying to conceive? Yes / No If yes, how long have you been trying? _____

NUTRITION & DIET

Please tick those that best describe your NORMAL daily routine:

- ☐ Meat & 3 Veg
- ☐ Vegetarian
- ☐ Vegan
- ☐ Wheat Free
- ☐ Gluten Free
- ☐ Dairy Free
- ☐ Sugar Free
- ☐ Regular take-out
- ☐ Processed foods
- ☐ Crave sugar/sweets
- ☐ Coffee _____ a day
- ☐ Tea _____ a day
- ☐ Water _____ litres
- ☐ Other: _____

Food Intolerances: _____

What are your favourite foods? _____

Are your bowel movements: Daily / 3 x week / Weekly / Other: _____

HABITS, DRUGS & SUPPLEMENTS

Do you drink alcohol? Yes/No Daily/Weekly/Social How much? _____ Wine / Beer / Spirits

Do you smoke? Yes / No How long? _____ How many per day? _____

Do you take any of the following? *(Please provide details)*

- ☐ Minerals _____
- ☐ Vitamins _____
- ☐ Medication _____
- ☐ Other _____

REASON FOR BEING HERE

What is your PRIORITY to work on and what do you hope to achieve out of this session?

_____

_____

_____

DECLARATION

DECLARATION

I understand that by signing this form that the information provided is true and to the best of my knowledge. Changes to the above should be advised upon future visits. We are not Medical Practitioners. We do not treat disease – We balance energy. I also understand that all bills are to be settled at the conclusion of each session. Payment can be made by cash or by EFT. I agree to give 24 hours notice for cancellation or a cancellation fee may be charged.

I hereby give permission for Lisa Sellyn of Tranquil Heart Therapy to conduct Kinesiology on me.

Signed: _____ Date: _____