CHRISSY HOLLAND

• KINESIOLOGY •

CONFIDENTIAL CLIENT QUESTIONNAIRE

Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

Date of Birth: ___/___/___ Age: _____ Sex: M / F Marital Status: _____

Occupation: _____

Emergency Contact Name: _____ Phone: _____

GP: _____

Other health professional (s): _____

Have you ever experienced Kinesiology before? _____

Who may I thank for recommending you to our clinic? _____

HEALTH HISTORY:

Energy: (please circle) High Medium Low Variable

General Health: (please circle) Good Poor Variable

Have you ever had: Root canal therapy Y / N Sprained Ankle/s Y / N Mammogram/s Y / N

Major Surgery / Accidents / Illness: _____

_____

_____

_____

Past traumas (physical or emotional): _____

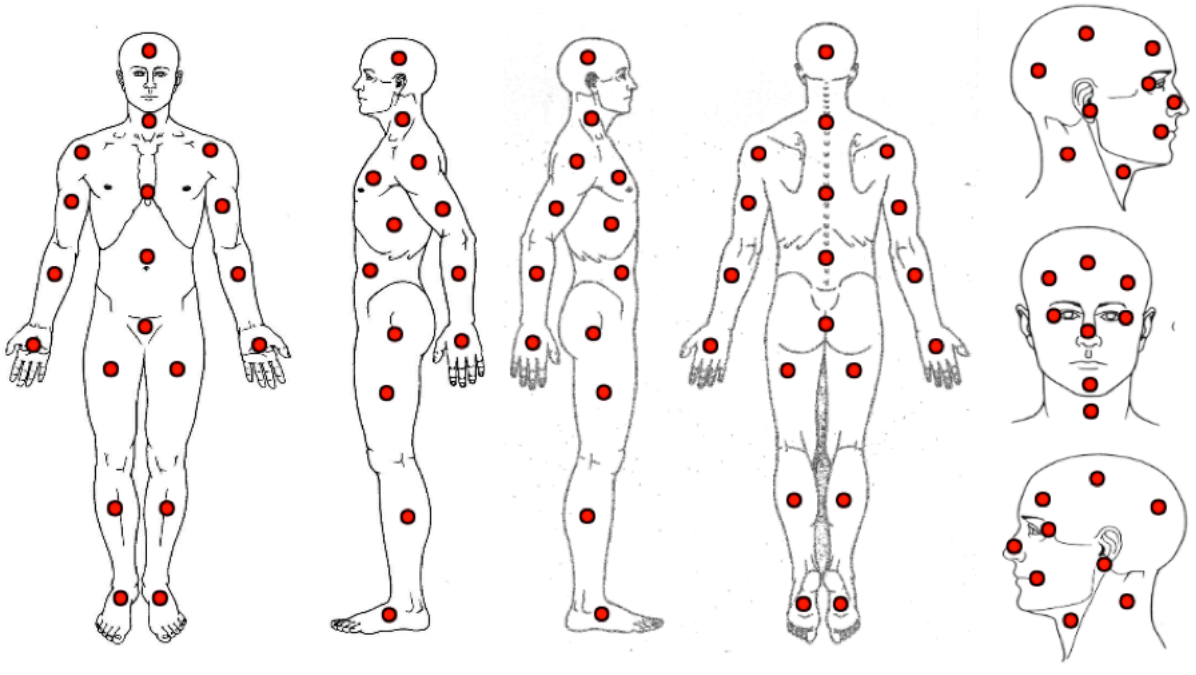
_____

_____

Are you pregnant or is there any possibility that you are pregnant? _____

If Yes, at what stage in the pregnancy are you? _____

Please indicate below the areas of the body where you are currently experiencing symptoms/pain:



Which of the above conditions is the worst? _____

Describe your symptoms/pain _____

LIFESTYLE:

How many hours do you usually sleep each night? _____

How well do you sleep? _____

How often do you exercise? _____

If applicable, what sort of exercise do you do and duration? _____

_____

What drugs (medical or recreational) are you presently taking? _____

_____

_____

What vitamins or mineral supplements are you taking? (include brand name and dosage): _____

_____

_____

DIET:

Please indicate your normal /general diet:

Meat & 3 Veg Vegetarian Vegan Paleo High Protein

Plant Based Dairy Free Gluten Free Other: _____

Daily: Coffee _____ Tea _____ Soft Drinks _____ Alcohol _____ Water (L) _____

What if any food cravings do you have? _____

REASONS WHY YOU ARE HERE:

Include history of current problem*

*NOTE: Be sure to answer in as much detail and honesty as possible so we can work together to maximise your results.

What would you like to work on in this Kinesiology session?

What do you not have in your life that you now want?

What relevant patterns have you noticed occurring in your life so far?

What are you putting off out of fear?

FAMILY HISTORY:

Please give brief details of any health problems in your family history

Relation: Current and / or past health problems:

DECLARATION:

I declare that the above information is true and correct and indemnify your clinic / practice of any liability for any false or misleading statements given. It is understood and accepted that the treatment given is a remedial therapeutic nature and not of a diagnostic/curative approach. It is also understood and accepted that the results of the treatment are not guaranteed in any way and that any data or notes taken during the sessions will remain the property of your clinic as part of the case history records. In addition, I understand that a copy of any kept personal records will be made available to me within 48 hours of my request at any such time and that my personal information, unless otherwise noted by me may be used by your clinic for notification of any future news products or services as deemed appropriate by your clinic. I am attending your clinic of my own free will and consent and exercise my right to discuss and choose any suitable treatments available to me.

I further understand that no account is rendered by your clinic and my payment is at the time of the service and can be made either by cash, card or bank transfer.

Patients Signature (Parent or guardian): _____

Patients Name: _____ Date: _____