Kinesiology - Client History Form

General Details

Name: ..... Today's Date: .....
Occupation: ..... Date of Birth: .....
Mobile: ..... Work: .....
Home: ..... Email: .....
Male ☐ Female ☐ If female, pregnant? Y ☐ N ☐ Current trimester: .....
Emergency Contact Name: ..... Number: .....

Reasons for seeking treatment

What areas of your life would you like to work with, i.e. overcoming physical / mental / emotional / spiritual issues, or setting and accomplishing goals etc?

.....

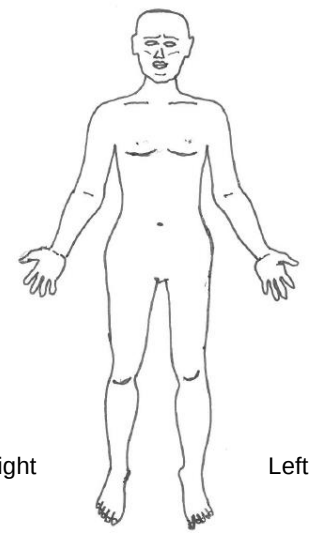
.....

Medical History *(please include date)*

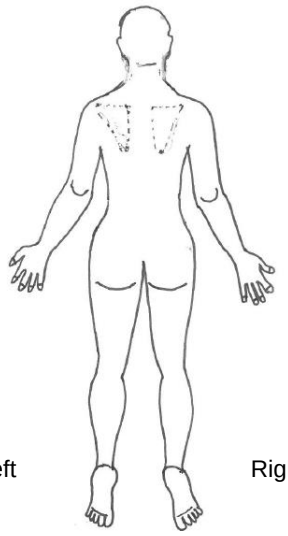
Conditions	Y	Details
Headaches / migraines / dizziness	☐	.....
Cardiovascular issues (heart/lungs)	☐	.....
Blood pressure (high / low)	☐	.....
Poor circulation (numbness / tingling)	☐	.....
Swollen Feet	☐	.....
Varicose Veins	☐	.....
Depression / anxiety / stress / sleeping difficulty	☐	.....
Tiredness / fatigue	☐	.....
Blood sugar issues	☐	.....
Dizziness / fainting	☐	.....
Digestive issues (allergies / intolerances / etc)	☐	.....
Hormonal issues (thyroid, etc)	☐	.....
Thrush/Candida	☐	.....
Menstrual/Menopausal	☐	.....
Skin conditions	☐	.....
Bacterial/Viral infections (warts, athletes foot, etc)	☐	.....
Regular colds and flu	☐	.....
Mental issues	☐	.....
Epilepsy	☐	.....
Cancer	☐	.....
Other (vision, hearing, brain, lung, gall bladder etc)	☐	.....
Musculoskeletal pain (muscles/joints/cramps/etc) *(Please also indicate on diagram on next page)*	☐	.....

Continued overleaf

Physical pain/discomfort
Chronic/Acute?



Right Left



Left Right

Past Traumas

Past Accidents ----------

Past Surgery ----------

Childhood illnesses ----------

Medications / Supplements	**Y**	**Details**
Drugs (medical/recreational)	☐	----------
Supplements	☐	----------

Other Treatments and Outcomes

Family History

Are you in a current relationship? *Please circle*: Spouse/Partner Relationship Single

Partner/Spouse (*first name*):

Number of brothers/sisters (*first names*):

Children (*first names*):

List any known health conditions which run in your family (*past and current*):

Diet and Lifestyle

Diet *Please outline what you might eat on a typical day:*

Breakfast ----------

Lunch ----------

Dinner ----------

Between meals ----------

Fruits ----------

Water/Alcohol/ coffee/other drinks ----------

Reactions

Are you aware of any allergic reactions or intolerances to food / supplements / products / chemicals / pollen / dust / fur or other?

Mental and Emotional

Mental

What is your overall mental state / ability to concentrate and motivate yourself to learn new things, to set goals, and to plan and complete tasks?

Emotional

What is your current emotional state? Do you have any phobias / fears /frustrations? Experience low confidence etc? *Also give one word for your current mood*.

Patterns or recurring life events

Are you sabotaging your best intentions / goals when all seems to be going so well?
Are you not able to save money in spite of how much you earn?
Are you attracting the same type of partner or situation in life?

How did you hear about us?

Please help us by ticking the appropriate box below.

☐ Word of mouth ☐ Flyer / Leaflet Introduced by: ☐ Street Presence ☐ Clinic website ☐ Search Engine

Client Acknowledgement and Consent

I acknowledge that:

- My therapist is not a medical professional and will not provide any diagnosis or medical advice.
- My therapist is not qualified to provide any natural remedy advice. Any guidance provided is based on direct bio-feedback obtained from the client's mind-body during the session.
- As with any intervention, there is always a small risk that the treatment could have negative effects. I confirm that I have stated all my known medical conditions and answered all questions honestly. I also agree to keep my therapist updated of any changes in my conditions.

I consent to:

- My contact details and treatment notes being stored securely by Ravel Therapies and accessed by its practitioners as required.
- My medical information and treatment notes being released to other medical and health practitioners if I request my therapist to do so.
- My therapist disclosing my personal information, if required to by law.
- Receiving appointment confirmation and reminder emails and text messages, as well as occasional newsletter emails from Ravel Therapies.

I understand and accept the following booking and payment terms:

- Appointments cancelled less than 24 hours from the time of the appointment will incur a charge of 50% of the full consultation fee.
- Consultation fees must be paid in full at the time of the consultation and can be by cash or credit card.

Client Signature: