Kinesiology
Client History Form

General Details

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

Reasons for seeking treatment

What areas of your life would you like to work with, eg overcoming problems whether physical / mental / emotional / spiritual, or setting and accomplishing goals etc?

_____

_____

_____

_____

_____

Medical History *(please include date)*

Conditions	Y	Details
Musculoskeletal pain (muscles/joints/cramps/etc)	☐	_____
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)	☐	_____
Menstrual/Menopausal	☐	_____
Skin conditions	☐	_____
Bacterial/Viral infections (warts, athletes foot, etc)	☐	_____
Regular colds and flu	☐	_____
Mental issues	☐	_____
Epilepsy	☐	_____
Other (vision, hearing, brain, lung, gall bladder etc)	☐	_____

Continued overleaf

Past Traumas

Past Accidents

Past Surgery

Childhood illnesses

Medications / Supplements	**Y**	**Details**
Drugs (medical and 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 and sisters:

Children (*first names and ages*):

Please list known health conditions (*past and* present) which run in your family:

Diet and Lifestyle

Do you smoke? If so, how many per day:

Do you exercise? If so, please describe:

Diet

Please outline what you might eat on a typical day:

Breakfast

Lunch

Dinner

Between meals

Fruits

Water intake

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? *Also give one word for your current mood*.

Patterns or recurring life events

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

How did you hear about us?

Please help us by ticking the appropriate box below.

☐ Word of mouth Introduced by: ---

☐ Referral Referring consultant: ---

☐ Flyer / Leaflet ☐ Street Presence ☐ Clinic website ☐ Search Engine

Client Acknowledgement and Consent

I acknowledge that:

- My therapist is not qualified to carry out a medical examination, and I agree not to interpret their comments as medical advice.
- My therapist is not qualified to provide a diagnosis, and I will not consider any advice given as such.
- 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.
- 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.
- A kinesiology session, in rare cases, could lead to a temporary feeling of light-headedness, energy or emotional highs and lows, or unexplained sleepiness.

I consent to:

- My medical information and treatment notes being accessed by other Ravel Therapies' practitioners.
- My medical information and treatment notes being released to other, third-party, health practitioners whom I agree for my therapist to refer me to.
- My therapist disclosing my personal information, if required to by law.
- Receiving occasional informative and/or promotional 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 at the time of the consultation, and can be by cash, or EFTPOS.

Client Signature: ---