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Health History Form

NAME .....

ADDRESS.....

..... Home Tel:.....

EMAIL ADDRESS:

EMPLOYMENT ..... Work Tel:.....

DATE OF BIRTH..... SEX: M/FWEIGHT. ..... HEIGHT.....

MARITAL STATUS: ..... CHILDREN: Y/N

NAME & ADDRESS OF MEDICAL DOCTOR .....

Are you at present under the care of a doctor, another therapist or hospital for your symptoms? If so, please give brief details including any medications or supplements which you are currently taking:-

.....
.....
.....

Have you taken antibiotics in the last 3 years Y/N

What are your reasons (conditions/symptoms etc) for wanting kinesiology?

.....
.....
.....

What are your expectations of kinesiology? .....
.....

Where did you hear of me: eg via a friend, brochure etc .....

<u>Please read and sign the following</u>

I understand that kinesiologists do not give medical diagnosis or treatment but do correct imbalances that are revealed during a session.

I further appreciate that it is my responsibility to consult my GP about any pain, problem or disease that I am presently aware of, or become alerted to the possibility of, as a result of a balance.

Signature ..... Date:.....

The information in this form will be helpful to your kinesiologist and will be treated in the strictest confidence.

Conditions, complaints, problems

In the following, please mark those items which apply to you and indicate the degree of severity in either or both columns by putting - 1 for Mild, 2 for Moderate, 3 for Severe

I have had	I have	Condition	I have had	I have	Problems
		Poor sleep/sleeping disorders			Regular colds/ Respiratory infections
		Vertigo			Diabetes
		Travel sickness			Constipation
		Hearing problems			Loose bowels
		Dyslexia			High blood pressure
		Fainting			Low blood pressure/ Poor circulation cold hands/feet
		Epilepsy			Anaemia
		Nervous twitching			Chronic tiredness Lethargy
		Headaches			Thrush
		Migranes			Menstrual
		Sight problems			Urinary
		Anxiety attacks			Sexual dysfunction
		Depression			Liver/gall bladder
		Chest pains			Asthma
		Neck/shoulder pains			Hay fever
		Low back pain/sciatica			Skin allergies/rashes
		Osteoporosis			Other allergies (specify)
		Arthritis			Food cravings (specify)
		Leg/knee pains			
		Painful feet			
		Other pain (specify)			

Do you smoke? YES/NO.
Do you have a special diet? eg vegetarian .....
Are you taking food supplements, if so which ones?.....
.....

Have you had any accidents resulting in broken bones, if so which bones?
.....
.....
Birth method - Natural birth ..... or C-Section ..... tick one if known

Have you had any serious operations, if so for what and when did these take place?
.....
.....

List any emotional traumas that you remember with approximate dates
.....
.....

What are your special interests/hobbies?
.....