*Kathleen Kinesiology*

**NEW CLIENT QUESTIONNAIRE – PRIVATE & CONFIDENTIAL**

# PERSONAL DETAILS

Title: \_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ P/code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you had Kinesiology before? Yes / No How did you hear about me? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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: \_\_\_\_\_\_ Star Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M / F Weight: \_\_\_\_\_\_\_kg

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

Which of the following best describes your current situation:

Study / Work F/T / Work P/T / Sole Trader / Business Owner / Stay at Home Mum / Retired

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long there? \_\_\_\_\_\_\_\_\_\_

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? \_\_\_\_\_\_

On a scale of 0-10 how would you rate your sleep quality? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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:

* Anger issues
* Anxiety / Nervousness
* Asthma
* 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
* Epilepsy
* Fatigue / Tiredness
* Fear (of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
* Financial stress
* Friend problems
* Grief (of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  Guilt (around \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
* Headaches
* Hearing impairment / Tinnitus
* Heart problems
* Hepatitis A, B, C
* Herpes
* High / low blood pressure
* Incontinence
* Insomnia
* Jaw pain or clicking / TMJ
* Joint pain
* Kidney pain / ailment
* Lack of energy
* Legal matters stress
* Liver damage
* Loneliness
* Marriage difficulties
* Memory recall
* Migraines
* Motivation lacking
* Muscle cramps / spasms
* Neck pain / tension
* Poor circulation
* Posture problems
* 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
* Vision impairment
* Weight trouble
* Work related stress
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

From the list above, please list any items you would specifically like to deal with:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# 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  Dairy Free  Crave sugar/sweets
* Vegetarian  Sugar Free  Coffee \_\_\_\_\_\_ a day
* Vegan  Artificial Sweeteners  Tea \_\_\_\_\_\_\_ a day
* Wheat Free  Regular take-out  Water \_\_\_\_\_\_ litres  Gluten Free  Processed foods  Other: \_\_\_\_\_\_\_\_\_\_\_\_

Briefly describe below your normal daily foods for:

Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your favourite foods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

# HABITS, DRUGS & SUPPLEMENTS, Vaccination Status

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)*

* Herbs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Homeopathic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Minerals \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Vitamins \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# REASON FOR BEING HERE

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

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# DECLARATION

I declare that the above information in true and correct and indemnify Kathleen Kinesiology of any liability for any false or misleading statements given. It is understood and accepted that the session provided by Kathleen Kinesiology is of a remedial therapeutic nature and not of a diagnostic/curative approach. It is also understood and accepted that the results of the session are not guaranteed in any way. The information gathered here, as well as all notes and information taken in every session, is kept safe and secure in a locked filing cabinet, it will remain the property of Kathleen Kinesiology as part of client history records. Personal information may be used for notification of any future news or services as deemed appropriate. I further understand that payment is to be made at the time of service and can be made by cash, direct bank transfer or credit card (includes processing fee). I agree to give 24 hours’ notice for cancellation of any appointment or a fee of $50.00 will be charged and as per Cancellation Policy. I hereby give permission for Kathleen O’Dowd to conduct Kinesiology on me.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_