Record Erin Rand

Client D.O.B: 23/07/1983
Created By: Auto
Business: Soma Holistic Health
Created On: 22/11/2023 3:07 pm
Activity Date: 22/11/2023 3:07 pm

Personal Details

The questionnaire requires a lot of very detailed information. This assists us to identify correlations between your symptoms so we can find the underlying cause/s of your presentations. It can look a little overwhelming but we recommend taking some time out with a cup of tea or coffee and working through the form. There is no pressure to disclose anything which makes you feel uncomfortable.

First Name
Erin

Last Name
Rand

Address
8 Bartley Street,

City
Mango Hill

State
QLD

Postcode
4509

Email
e.rand@qic.com

Mobile Phone

0450102655

Date of Birth
23/07/1983

Occupation
Manager

What is the Main Reason/s for your Visit
Stress, depression and anxiety due to family conflict which resulted in our 16 year old niece coming to live with my husband and our 7 year old twins. Her parents are both drug addicts/alcoholics.

Please list any Surgeries you have had (including year)
IVF egg retrievals - 2014/2015
Endometrial laparoscopy - 2014
Emergency caesarian 2015 (26 weeks pregnant due to severe pre-eclampsia)
Compound fracture toe 2018

Please list any Medications you take regularly (if none, please write Nil)
Citalopram 20mg
Insulin

Please list any Supplements you take regularly (if none, please write Nil)
nil

Please list any major childhood illnesses, health conditions or accidents (if none, please write Nil)
nil

Please list any allergies you have (including food, medications or essential oils)
Nil

Please list if there is a family history of any medical or genetic health conditions (ie. Cancer, High Blood Pressure, High Cholesterol, Parkinson's Disease, Alzheimer's Disease etc)
Cancer
Heart disease
High cholesterol

Do You Have a Pacemaker?
No

Are You Currently Pregnant?
No

Have you experienced Kinesiology before?
Yes

How Did You Hear About Soma Holistic Health
Google

Emergency Contact Details
We require these details just in case you suffered a medical episode whilst under our care. The details of your Kinesiology session would not be disclosed.

Name of Person:
Russell Rand

Relationship
husband

Contact Number
0406721891

General Medical History

Please select any of the below conditions / symptoms that you have experienced in the past or are experiencing now (can select multiple answers)
Diabetes, Digestive Symptoms (further questions are on the following pages), Mental Health Concerns (further questions are on the following pages), Reproductive Symptoms or Dysregulation (further questions are on the following pages)

If you selected any of the responses above, please provide some further information ie. Year diagnosed, test results, diagnosis, treatment
Type 1 Diabetes - diagnosed 2021
Reproductive issues PCOS/Endometriosis - first diagnosed around 2010 with PCOS and endo 2014
Depression/Anxiety - first diagnosed in 2003
Please list any other conditions or concerns not listed above
Nil

Mental Health & Emotional Issues

Please select any of the below conditions / symptoms that you have experienced in the past or are experiencing now (can select multiple answers). If you have don't experience any mental health symptoms, please move onto the next section
Anxiety (generalised or social), Depression, Mental or Emotional Exhaustion, Grief (unresolved), Overwhelm (regular), Post Natal Depression, Post Traumatic Stress (PTS) including Complex Post Traumatic Stress (CPTS), Suicidality

If you selected any of the responses above, please provide some further information ie. Year diagnosed, test results, diagnosis, treatment
Depression/anxiety/suicidality - first diagnosed in 2003 and treated with anti depressant medication and therapy over the last 20 years
PTSD/PND/Grief - following the premature birth of my twins at 26 weeks in 2015
Please list any other mental health conditions or concerns not listed above
Please select whether you are under the care of one or more of the following mental health practitioners
Psychologist

Digestive Issues

Please select any of the below conditions / symptoms that you have experienced in the past or are experiencing now (can select multiple answers). If you have don't experience any digestive symptoms, please move onto the next section
Bloating, Diarrhoea, Heartburn

If you selected any of the responses above, please provide some further information ie. Year diagnosed, test results, diagnosis, treatment
Heartburn diagnosed in pregnancy and has continued following birth. Usually triggered by certain foods.
General bloating and loose bowl motions from time to time - have been tested for coeliac and negative
Please list any other digestive conditions or concerns not listed above

Reproductive Issues (Females Only)

Please select any of the below conditions / symptoms that you have experienced in the past or are experiencing now (can select multiple answers). If you have don't experience any reproductive symptoms, please move onto the next section
Endometriosis, Fertility Issues, Miscarriage, Ovarian Cysts, PMS, Polycystic Ovarian Syndrome (PCOS)

If you selected any of the responses above, please provide some further information ie. Year diagnosed, test results, diagnosis, treatment
PCOS diagnosed in 2010
Endometriosis diagnosed 2014
Unexplained Infertility 2013 (resulting in 4 rounds of IVF)
Please list any other reproductive conditions or concerns not listed above

Structural Issues

If you selected Structural Issues in the first section, please complete this page. Otherwise, scroll down to the next section.
Back Pain (please also mark on diagram below)
Yes

If you answered yes, what would you rate your back pain out of 10 (with 1 being none and 10 being excruciating)
5 /10

Neck Pain (please also mark on diagram below)

If you answered yes, what would you rate your neck pain out of 10 (with 1 being none and 10 being excruciating)
/10

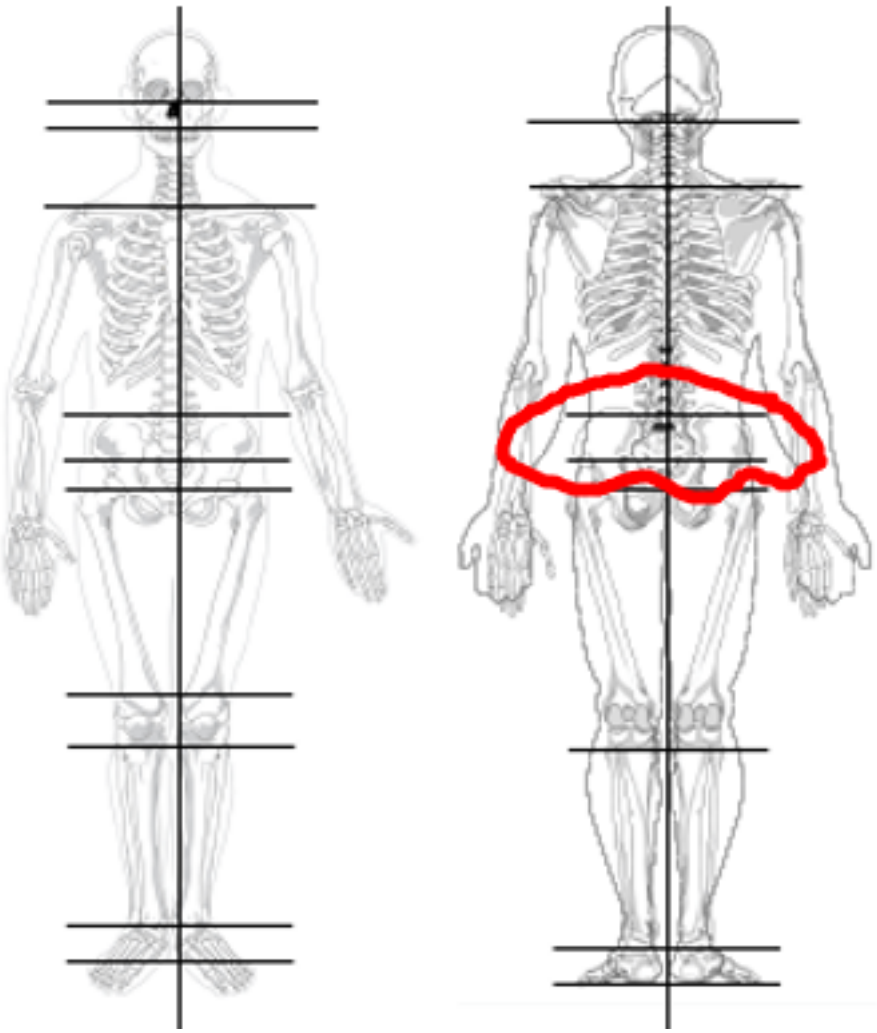
Hip Pain (please also mark on diagram below)

If you answered yes, what would you rate your hip pain out of 10 (with 1 being none and 10 being excruciating)
/10

Shoulder Pain (please also mark on diagram below)

If you answered yes, what would you rate your shoulder pain out of 10 (with 1 being none and 10 being excruciating)
/10

Please mark any areas that cause you pain or discomfort. You can colour the affected area or draw an arrow to the injury. You can also add text by selecting the text button and double clicking near the affected area.



Please list any events that resulted in major physical injury ie. car accidents, major falls etc.
nil
Please list any other structural conditions or concerns not listed above

Viruses

Please select any of the below conditions / symptoms that you have experienced in the past or are

experiencing now (can select multiple answers). If you have don't experience any mental health symptoms, please move onto the next section
Coronavirus, Glandular Fever (mononucleosis), Human Papillomavirus (HPV)

If you selected any of the responses above, please provide some further information ie. Year diagnosed, test results, diagnosis, treatment
Coronavirus - 2022
HPV - 2004
Glandular Fever - 1999
Please list any other viral conditions or concerns not listed above

Diet and Nutrition

Please select any of the answers that reflects your current daily food routine (can select multiple answers)
Meat and 3 Vegetables, Gluten-free, Low-carb

Do you crave sugar or sweets?
Yes

Do you crave salty carbs?
Yes

Do you smoke or vape?
No

How many standard alcoholic drinks do you consume weekly on average?
nil

How much water do you dink daily on average?
2-3 litres

Medical Reports and Tests

Please upload any relevant Medical Reports or Tests that will help us to understand your current health condition/s.

Client Consent

I give my consent for Kinesiology treatment, and understand my session is confidential. I understand that I may withdraw this consent either verbally or written at any time.
Yes

Declaration
I declare the information provided in the Client Intake Form is true and correct. To the best of my knowledge, I have disclosed all information regarding my past and present state of health. I understand it is my responsibility to inform my Kinesiologist of any changes to medication, major illnesses, or health conditions in subsequent visits. (Please refer to the Informed Consent form for detailed information relating to consent).
Name
Erin Rand

Signature