Record Silvana Ribeiro

Client D.O.B: 28/12/1981
Created By: Auto
Business: Soma Holistic Health
Created On: 11/09/2023 4:00 pm
Activity Date: 11/09/2023 4:00 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
Silvana

Last Name
RIbeiro

Address
11/25 Th Corso

City
North Lakes

State
Qld

Postcode
4509

Email
Silvana28@ymail.com

Mobile Phone

0422287849

Date of Birth
28/12/1981

Occupation
Mother

What is the Main Reason/s for your Visit
In Pain due to Inflamation, Psoriasis and Arthritis
Please list any Surgeries you have had (including year)
nil
Please list any Medications you take regularly (if none, please write Nil)
nil
Please list any Supplements you take regularly (if none, please write Nil)
Ashwagandha, Turmeric, Curcumin, black seed oil and celtic salt.
Please list any major childhood illnesses, health conditions or accidents (if none, please write Nil)
Under active thyroid, anxiety, upset stomach and trauma.
Please list any allergies you have (including food, medications or essential oils)
Currently cannot tolerate dairy, sugar, nightshades, spicy food, meat and carbs.
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)
Schizophrenia, depression, psoriasis and arthritis.
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
Other

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:
Rick Ribeiro

Relationship
Husband

Contact Number
0425706385

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)
Adrenal Fatigue, Allergies, Arthritis (including Osteoarthritis or Rheumatoid Arthritis), Auto-Immune Disease, Blood Pressure (high or low), Chronic Pain, Skin Conditions (including Eczema or Dermatitis), Thyroid dysfunction (Hyperthyroid or Hypothyroid), Tiredness / Fatigue

If you selected any of the responses above, please provide some further information ie. Year diagnosed, test results, diagnosis, treatment
I have had Psoriasis for 10 years with no effective treatment by doctors, dermatologist. I have psoriatic arthritis with no successful treatment by Rheumatologist. I had an underactive thyroid and took medication for treatment while pregnant 10 years ago. I feel that my thyroid could also be sick and noone has picked up on it they keep saying its normal. My body tells me otherwise.
Please list any other conditions or concerns not listed above

I had an underactive thyroid and took medication for treatment while pregnant 10 years ago. I feel that my thyroid could also be sick and noone has picked up on it they keep saying its normal. My body tells me otherwise. Would like this also looked at as well as Psoriasis and Arthritis. I feel burnt out.

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), Concentration (difficult to maintain focus), Depression, Mental or Emotional Exhaustion, Excessive Worry, Fear of the Future, Grief (unresolved), Memory issues, Mood Swings, Motivation (lack of), Nightmares / Night Terrors, Obsessive Compulsive Disorder (OCD), Self-worth (low)

If you selected any of the responses above, please provide some further information ie. Year diagnosed, test results, diagnosis, treatment

Please list any other mental health conditions or concerns not listed above

I am in pain and have been so for the past 6 months. I have so much to do and no help from anyone, I home-school, have chores, no friends or family here. Moved from Melbourne 2 years ago and recently moved to the Sunshine Coast 2 months ago to North Lakes. I feel burnt out everyday.

Please select whether you are under the care of one or more of the following mental health practitioners

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, Heartburn, Weight Gain / Loss (unexplained)

If you selected any of the responses above, please provide some further information ie. Year diagnosed, test results, diagnosis, treatment

not tolerating a lot of foods

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

Heavy Periods, PMS

If you selected any of the responses above, please provide some further information ie. Year diagnosed, test results, diagnosis, treatment

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)

No

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

/10

Neck Pain (please also mark on diagram below)

No

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

/10

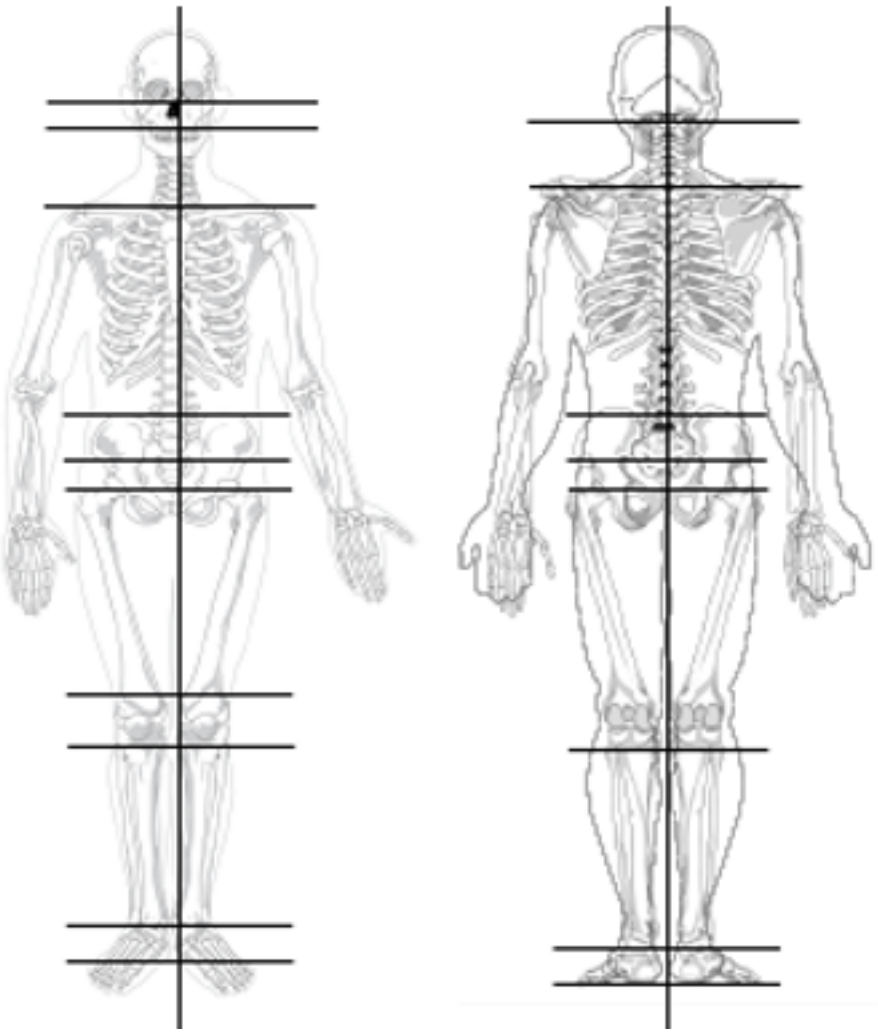
Hip Pain (please also mark on diagram below)
No

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)
No

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.
no

Please list any other structural conditions or concerns not listed above
very sore right foot, limping due to Arthritis pain.
sore knuckle right hand due to Arthritis.

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

If you selected any of the responses above, please provide some further information ie. Year

diagnosed, test results, diagnosis, treatment
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)
Vegetarian, Gluten-free, Dairy-free, Sugar-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?
I used to have a beverage once a week but cannot tolerate alchohol atm

How much water do you dink daily on average?
2 bottles a day

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
Silvana Ribeiro

Signature