New Client Intake Form

SOMA holistic health

5/25 Discovery Drive, North Lakes Q 4509
Email: info@somaholistichealth.com.au

Name:				Email: info@somaholistichealth.com.au Mb: 0427 466 742		
Date of Birth:					.007.12	
Contact Number						
Email Address						
Address:						
Would you like to receive our monthly newsletter?	Yes	No				
I found out about Kinesiology through Friend	Google	Facebook	Referral	Other		
Reason for visit						
Please list any						
surgeries (including dates)						
Current						
medications						
Current						
supplements						
Your safety and comfort are our top priority. Please advis	se us if there	are any cultural s	ensitivities the	at vou would lil	ce us to	
be aware of.	30 43 II 111616	are arry curtural st		it you would lif	ic us ic	
Do you have any internal devices such as a pacemaker?	, No	Yes				
Are you pregnant?	No	Yes				

Test results (blood tests, pathology, histology, X-Rays, MRIs) provide really great information so if you have any test results please bring them to your appointment

MEDICAL HISTORY

The medical history provides valuable clues to the underlying cause/s of the symptoms you may be experiencing. Please tick any relevant medical conditions, viruses, vaccinations, mental health and emotional concerns.

MEDICAL

Adrenal fatigue Diabetes HIV/AIDS Peripheral neuralgia Digestive condition Hormone imbalance PMS Allergies Arthritis Dizziness/ vertigo POTS Asthma Dysmenorrhoea Insomnia/sleeping issues Reproductive issues Auto-immune Eating disorder Joint pain/swelling/stiff Respiratory issues Eczema/dermatitis Kidney conditions Scoliosis Back pain Blood Pressure (high/low) Endocrine condition Lime Disease Sinus pain/congestion Broken bones Endometriosis Skin conditions Lupus Cancer Epilepsy/seizures Lymphoma Spinal injury Multiple sclerosis Chronic Fatigue Syndrome Excessive sweating Sprains/strains Chronic Pain Fibromyalgia Muscle tension/cramps Stress Cold/Flu/Fever **GERD** Musculoskeletal pain/injury Thyroid Coeliac disease Grave's disease Neck pain/tightness Tinnitus Constipation/Diarrhea Hay Fever Nervous system issue Tiredness/fatigue Crohn's disease Headaches/migraines Numbness/tingling Varicose veins Dental condition Heart condition Osteoporosis Visual impairment

VIRUSES

Mumps

Hepatitis C

Chicken Pox/Shingles (HHV3)

Human Herpes Virus 1 (cold sores) Norovirus Adenovirus Avian influenza (bird flu) Human Herpes Virus 2 (genital herpes) Polio Coronavirus Ross River Fever Epstein Barr (HHV4) Spike Protein (SARS-CoV-2) Dengue Fever Cytomegalovirus (HHV5) Human papillomavirus (HPV) Swine Flu Enterovirus 7ika virus Hepatitis A Huma parainfluenza virus (croup) Hepatitis B Measles

MENTAL HEALTH

ADHD Obsessive compulsive disorder (OCD) Motivation (lack of) Paranoia Concentration Agoraphobia Anxiety (general) incl. panic attacks Brain fog Post-traumatic stress disorder (PTSD) Bipolar Memory issues Claustrophobia Addiction/substance abuse **Psychosis** Schizophrenia Mood swings Depression Dissociation/dissociative disorders Sensitivity to light or sound Negative thoughts Eating disorder Suicidality Social phobias/anxiety

EMOTIONAL HEALTH

Aggression Grief/loss Relationship issues

Alienation Guilt Resentment
Anger/Rage Hopeless Sadness
Avoidance of feelings Indifference Self-doubt

Communication issues Judgement Self-esteem issues

Despair Loneliness Self-image

Excessive worry Nervousness Self-worth issues

Exhausted (emotionally) Overwhelm Shame

Fear Panic Stubbornness

Fear of failure Rapid weight gain (more than 5 kg) Suppression of feelings

Fear of Success Rapid weight loss (more than 5kg) Terror

VACCINATIONS

Chicken pox Flu shot Pneumococcal

Coronavirus (AstraZeneca)Hepatitis BPolioCoronavirus (Moderna)Human papillomavirus (HPV)RotavirusCoronavirus (Novavax)Measles & MumpsRubellaCoronavirus (Pfizer)MeningococcalShinglesDiphtheriaPertussis (whooping cough)Tetanus

FAMILY HISTORY (Immediate Family)

Cancer	Self	Father	Mother	Sibling
Tuberculosis	Self	Father	Mother	Sibling
Diabetes	Self	Father	Mother	Sibling
Heart conditions (incl. blood pressure)	Self	Father	Mother	Sibling
Parkinson's disease	Self	Father	Mother	Sibling
High Cholesterol	Self	Father	Mother	Sibling

What other forms of therapy do you use to resolve health problems?

Doctor Acupuncture Massage
Specialist Naturopathy Reflexology

Chiropractic Osteopathy Psychologist/Psychiatrist/Counsellor

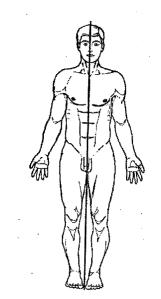
Physiotherapy Herbalist Other

Please tick those that best describe your normal daily food routine

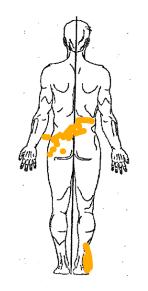
Meat & 3 Veg	Keto	Low-Carb	Low-fat	Crave sugar/sweets
Vegetarian	Gluten Free	Mediterranean	Diabetic diet	Crave salty/carbs
Vegan	Dairy Free	FODMAP	Atkin's diet	Regular take out
Paleo	Sugar Free	Inulin Free	Specialised diet	Other

STRUCTURAL CONCERNS

If you are currently experiencing any structural issues or misalignments, please complete the chart below







Body Area	Description of Misalignment		

Any other information you wish to disclose:				

CLIENT DECLARATION

I declare that the above information is true and correct. I understand that it is my responsibility to inform my Kinesiologist of any changes to medication and major illnesses or conditions in subsequent visits. I understand and accept that Kinesiology is a complimentary therapy and is in no way diagnostic or curative. I understand and accept that the results of the treatment are not guaranteed in any way.

I understand and accept that any personal information I provide in the Confidential Client Information Form and notes made by the therapist in my Session Records, will remain the property of the clinic and will be securely stored and kept in strict confidence. I am aware that I may request in writing, to view or access copies of the records detailing my personal information, which is held by the clinic.

I understand and accept that my written permission is required to provide consent to any records that detail my personal information, being disclosed to any other party. I am also aware that I am able to view the Privacy Policy of the clinic at any time.

Name:			
Date:			