

New Client Intake Form



5/25 Discovery Drive, North Lakes Q 4509

Email: info@somaholistichealth.com.au

Mb: 0427 466 742

Name:

Date of Birth:

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 advise us if there are any cultural sensitivities that you would like us to be aware of.

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.

PHYSIOLOGICAL

Adrenal fatigue	Diabetes	HIV/AIDS	Peripheral neuralgia
Allergies	Digestive condition	Hormone imbalance	PMS
Arthritis	Dizziness/ vertigo	IBS	POTS
Asthma	Dysmenorrhoea	Insomnia/sleeping issues	Reproductive issues
Auto-immune	Eating disorder	Joint pain/swelling/stiff	Respiratory issues
Back pain	Eczema/dermatitis	Kidney conditions	Scoliosis
Blood Pressure (high/low)	Endocrine condition	Lime Disease	Sinus pain/congestion
Broken bones	Endometriosis	Lupus	Skin conditions
Cancer	Epilepsy/seizures	Lymphoma	Spinal injury
Chronic Fatigue Syndrome	Excessive sweating	Multiple sclerosis	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

Chicken Pox/Shingles (HHV3)	Hepatitis C	Mumps
Adenovirus	Human Herpes Virus 1 (cold sores)	Norovirus
Avian influenza (bird flu)	Human Herpes Virus 2 (genital herpes)	Polio
Coronavirus	Epstein Barr (HHV4)	Ross River Fever
Dengue Fever	Cytomegalovirus (HHV5)	Spike Protein (SARS-CoV-2)
Enterovirus	Human papillomavirus (HPV)	Swine Flu
Hepatitis A	Huma parainfluenza virus (croup)	Zika virus
Hepatitis B	Measles	

MENTAL HEALTH

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

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 B	Polio
Coronavirus (Moderna)	Human papillomavirus (HPV)	Rotavirus
Coronavirus (Novavax)	Measles & Mumps	Rubella
Coronavirus (Pfizer)	Meningococcal	Shingles
Diphtheria	Pertussis (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?

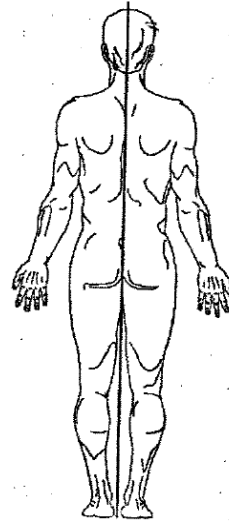
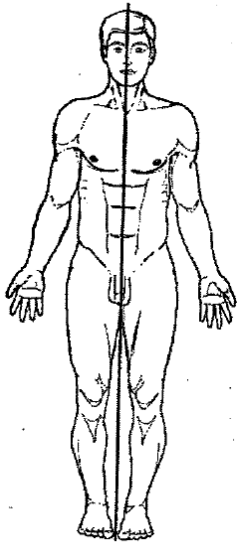
Doctor	Acupuncture	Massage
Specialist	Naturopathy	Reflexology
Chiropractic	Osteopathy	Psychologist/Psychiatrist/Counsellor
Physiotherapy	Herbalist	Other

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: