Client Intake Form – Bendigo Kinesiology

Name: _____What would you like me to call you?: _____

D.O.B:_____/_____/_____ Age: _____ Gender: □ Male □ Female

Address: _____

_____

Home phone: _____ May I leave a message? □ Yes □ No

Mobile Phone: _____ May I leave a message? □ Yes □ No

Email: _____ May I email you? □ Yes □ No

Family position: (eg. first born): _____ Do you have any children, if so, how many? _____

Marital Status: □ Single □ Boy/Girlfriend □ Defacto □ Married □ Separated □ Divorced □ Widow/er

Occupation/School year: _____ Employer/School: _____

Previous occupation: _____ Employer: _____

Who may I thank for referring you? How did you hear about Bendigo Kinesiology? _____

What is your primary reason/concern for coming here today? Current health/emotional/learning concerns. Describe current level of stress, discomfort or pain each issue is causing in your life. (0 no stress – 10 extreme).

_____ _____

_____

_____

_____

_____

_____

When did the problem first appear? _____

Did anything occur 18mths to 2yrs prior to this issue? _____

What treatments have you had for this issue? _____

Does anything make it worse/better? _____

Ideally after the session, I would like to feel (3 words) _____

In the process of improving your health, wellbeing and vitality, what % responsibility do you think is your own/practitioners? _____% You _____% Practitioner.

Please indicate any medications / supplements you take and why.

_____

_____

On a scale of 0 (Poor) – 10 (Excellent), rate the following:

General physical health and immune status: _____ Mood: _____ Social health: _____

Stress levels: _____ Daily energy levels: _____ Self-worth: _____ Relationships: _____

Allergies or Sensitivities: (Earth, SP Chakra)

Particular food/plants. If no known allergies, how do you feel after eating bread, pasta, refined foods, dairy or sugar?

_____

_____

In utero history
Did mother suffer any shocks, financial stress, emotional or mental, and trauma, viral or bacterial illness, exposure to toxins? _____

_____

Birth type: □ Natural □ Caesarian.
APGAR score:_____
Were forceps used in the delivery? □ Yes □ No
Was the delivery: □ Early □ Late? Weeks? _____
Was there separation at birth? □ Yes □ No How long?
Was your conception? □ Planned □ Surprise
Was the pregnancy? □ Easy □ Difficult
Were you breastfed? □ Yes □ No
Were there feeding problems? □ Yes □ No
Age first roll commenced: _____
Age first commando crawled: Y/N_____
Age first crawled: Y/N_____
Age first walked: _____
Any emotional/mental stress in the family in the early part of your life? □ Yes □ No _____

_____

Do you have siblings? □ Yes □ No How old were you when they were born? _____

_____

Did you have all normal childhood vaccinations? Y/N
Were there any reactions? □ Yes □ No

For the following systems of the body – ○ if present, ✓ if in the past.

Circulatory (Fire-Blood & BP, Heart Chakra)
❒ Stroke
❒ Heart Disease
❒ Hyper / Hypotension
❒ Cold hands/feet
❒ Varicose veins
❒ Swollen ankles
❒ Angina
❒ Blood disorders

_____

_____

Urinary (Water, Sacral Chakra)
❒ UTI
❒ Cystitis (Bladder)
❒ Kidney Stones
❒ Nephritis (Kidney infection/pain)
❒ Increased/decreased flow
❒ Passing urine at night
❒ Bed wetting

_____

_____

Respiratory (Metal – breathing, Fire – Chest & breathing, SP & Base Chakra)
❒ Cough
❒ Bronchitis
❒ Asthma
❒ Sinusitis
❒ Hay fever
❒ Wheezing
❒ Shortness of breath
❒ Snoring

_____

_____

Gastrointestinal (Earth, SP Chakra)
How often do you use your bowels? _____
❒ Halitosis
❒ Constipation
❒ Diarrhoea
❒ Candida
❒ Bloatedness
❒ Hernia
❒ Celiac Disease
❒ Indigestion
❒ I.B.S
❒ Ulcer
❒ Flatulence
❒ Cramps/pains
❒ Crohn's Disease

_____

_____

Endocrine (Fire, Earth, Kidney)
❒ Diabetes
❒ Sugar handling problems
❒ Thyroid
❒ Menopausal
❒ Hirsutism (Excess body facial/body hair)
❒ Gynecomastia (Male with breasts)

_____

_____

Musculoskeletal (Water-Bones, Wood-Sinews/Flexibility)
❒ Rheumatoid Arthritis (Inflammation)
❒ Osteoarthritis (Wear & Tear)
❒ Back/ neck pain
❒ Plantar Fasciitis
❒ Joint pain/stiffness/gout
❒ Muscular weakness/cramps
❒ Jaw pain
❒ Repetitive strain injury.

_____

_____

Reproductive (CV, GV, PC, Ki, LV)
❒ Reproductive cancer
❒ Low Libido
Female only
❒ Sexual function
❒ PMS
❒ Periods – Regular/irregular/painful/heavy
❒ Menopausal
❒ Endometriosis/ PCOS
❒ Miscarriages/Terminations
❒ Contraception: _____
❒ If pregnant, term? _____
Male only
❒ Erectile dysfunction
❒ Prostrate

_____
_____

Skin (Fire-Skin eruptions, Metal, LU, Chakra)
❒ Dermatitis
❒ Acne
❒ Itching
❒ Psoriasis (Auto-immune)
❒ Eczema
❒ Poor wound healing

_____
_____

Neurological (Brain function, CV, GV, Bl, GB, Chakra)
❒ Gait problems
❒ Tremors
❒ Epilepsy
❒ Loss of sensation
❒ Balance issues
❒ Migraines
❒ Headaches

_____
_____

Senses (Elements & meridians, senses points)
❒ Hearing/Tinnitus
❒ Vision
❒ Taste
❒ Smell
❒ Sensory perception problems
❒ Travel/sea/motion sickness

_____
_____

Surgery - Anaesthetics

_____
_____

Current infections
❒ Bacterial
❒ Viral
❒ Candida

_____
_____

Relevant past infections
❒ Glandular Fever
❒ Hepatitis
❒ Candida

_____
_____

Sleep Pattern (Fire-sleep disturbances & insomnia, elemental clock)
❒ Difficulties getting to sleep
❒ Poor quality sleep
❒ Disturbing dreams
❒ Sleeping too little / too much.
❒ Do you always wake at a specific time during the night? If yes, what time/s ? _____

_____
_____

Dental History
❒ Fillings (Mercury)
❒ Crowns
❒ Root canals
❒ Dentures
❒ Implants
❒ Orthodontic work
❒ TMJ Problems

_____
_____

Behavioural Patterns (Fire): Mood swings, patterns of feelings/thoughts, nervousness, anxiety, stress, depression, anger, panic attacks, phobias.)

_____
_____
_____
_____
_____
_____

Accidents/Trauma/Abuse

_____
_____
_____
_____
_____
_____
_____
_____

Lifestyle

	Yes	No	Details
Water Intake			Glasses per day?
Exercise			None/Occasionally/Often/ Daily. Details=
Relaxation/Meditation			None/Occasionally/Often/ Daily. Details =
Tea/Coffee/Caffeine drinks			Cups per day (Tea): _____ Cups per day (Coffee): _____ Drinks per day (Other caffeine drinks): _____
Alcohol			Standard drinks per week: _____ Type: _____
Cigarettes			Per day: Type:
Recreational drugs			Frequency: Type:

Diet

	Yes	No	Details – How many servings a week would you consume this?
Meat			1 serving = Size of your palm.
Fish			
Chicken			
Vegetables			Servings per day? (1 serving = 1 cup salad or ½ cup cooked)
Fruit			Pieces per day?
Sugar / Sweets / Cakes			
Breads / Pasta / Grains			
Nuts/ seeds (Not peanuts)			
Dairy			

Are you Vegetarian / Vegan? □ Yes □ No

What do you consider to be your strengths? What do you like about yourself?

Is there anything else you would like me to know about you?

All personal information is kept in strict confidence and not shared with any third party without your consent. Information is collected to assist me to better understand your needs so that I can provide the best possible service for you.

By signing below:

- I understand that payment is requested at the conclusion of the appointment.
- I understand the Bendigo Kinesiology does NOT directly treat any physical disease, disorders, and ailments. Kinesiology is for the body's underlying energy system. Kinesiology is a complementary health program and does not diagnose conditions or diseases, nor does it replace the care of your GP.

_____ _____

SIGNATURE DATE

(Parent/guardian signature for under 18)