

PERSONAL INFORMATION AND GOALS

In preparation for your Kinesiology session, please fill in this questionnaire. It will save a lot of time at your first session, and doing it at home allows you to relax, remember, and record everything that may be relevant to help you achieve your goals. Please skip sections that may not be relevant to you and feel free to attach extra sheets if you think it might be helpful to our work together, including interesting reports from your Doctor, homoeopath or other alternative practitioners.

Confidential Client Questionnaire	Family name
	First Name
Date	Address
Date of birth	
Occupation	
How did you find out about me?	
	Phone, Daytime
Doctor's name	Phone, Evening
Practice name	Mobile

Family situation	Single? Living alone? Living with parents? Living with partner? Married? Separated? Other?
If a child, parent's names	
Spouse/ partner's first name	
Children: names & ages	

Weight	Height
Are you happy with your weight?	If not, what is your ideal weight?

What other treatments are you having / have tried?

Medical history	Any past surgery, serious illness, accidents/injuries with approximate dates
What was your health like as a child?	
Was there anything abnormal about your birth?	

What areas, problems or goals would you most like help with now?

List any emotional traumas/ episodes, with rough dates, as far back as you like. (eg. bereavements, divorce, parents split-up etc.)

Any relationship problems

Diet Describe a typical day's eating & drinking:

Breakfast

Lunch

Evening meal

Between meals

What do you do for exercise and relaxation?

Medication Any current drugs & what for?

Any medication taken in the past, especially if for a long period

Have you reacted to any medication? Y/N What & how?

Do you smoke? Y/N If so, what & how many a day?

Do you drink? Y/N If so, what & how often?

Do you use recreational drugs? Y/N If so what & how often?

If not now, have you in the past? Y/N If so what?

	I am having (tick + any comment such as for how long)	I have had, but not now (tick + any comment such as when)
Poor sleep		
Dizziness		
Anxiety		
Depression		
Fainting		
Fits		
Nervous twitches/ tremors		
Headaches		
Migraines		
Vision problems		
Hearing problems		
Physical abuse		
Emotional abuse		
Sexual abuse		
Chest pains		
Pain; neck/ shoulder		
Pain; back		
Pain; joint		
Pain; other		
Constipation		
Loose bowels		
Poor circulation		
Lethargy		
Genital problems		
PMT /Menstrual problems		
Menopausal problems		
Low sex drive		
Other sexual problems		
Breathing difficulty		
Repeated infections		
Sore throat		
Sneezing		
Runny nose		
Runny eyes		
Stuffy sinuses		
Skin rash		
Spotty skin		
Food cravings		
Known allergic reactions		
Other problems		

Please read and sign the following statement

I understand that kinesiologists do not give **medical** diagnoses or treatment, and that it is my responsibility to consult my GP about any medical problem that I am aware of or become alerted to in the course of a kinesiology session.

Signed

Date