Retuning Me – Client Initial Consultation Record

Name:	Age/DOB:	Gender:
Address:	Height:	Profession:
	Weight:	Marital Status:
		Children/ages:
Email:	Tel:	

Personal Medical History (Accidents/injuries/operations/serious infections)	Dates

List Current (and Past if relevant) Medications and length of time taken:

Family Medical History (Conditions that have been in your family line, parents, grandparents/blood relations)	Dates
Maternal:	
Paternal:	

Stiffness, **A**ches, **P**ains or **C**ramps in your muscles or joints – Please fill in **S**/**A**/**P**/**C** in spaces below

Neck		Upper Back		Fingers		Upper legs front		Toes	
Shoulders		Middle Back		Hands		Upper Legs back		Feet	
Jaw		Lower Back		Wrists		Lower legs		Ankles	
Ribs		Elbows		Arms		SI Joints/Hips		Pelvis	

Please tick any of the following that you have in the past or currently suffer from:

Heart Problems		High BP		Cholesterol		Fluid Retention		Tired Legs	
Cold Hands/Feet		Angina		Liver Issues		Gall Bladder Pain		Varicose Veins	
Kidney Infections		Cystitis		Bladder Infections		Poor Control of urination		Chest Pain/tightness	
Regular Colds		Sinusitis		Chest Infections		Throat Infections		Tonsillitis	
Sensitive to light		Headaches		Migraine		Tension		Appendectomy	
PMT		Depression		Anxiety		Prostate Pain/lumps		Lumpy Breasts	
Constipation		Bloating		Pass Wind often		Stomach Pain		Indigestion	

List Foods and Beverages you may not be able to tolerate:	**List any <u>Nutritional Supplements</u> you are taking and supplier:**
List Fruits you eat generally:	**List Vegetables you eat generally:**
List Beverages you take daily and how often:	**List Types of Meat and Fish (other sources of protein) you eat:**
List Dairy/Wheat Produce you take and how often:	**List treats you have and how often:**

How often do you take the following?

	None	Daily	Weekly	Monthly	Less		None	Daily	Weekly	Monthly	Less
Fried Food						**Salt**					
Take Away						**Bread**					
Chips						**Painkillers**					
Chocolate						**Antibiotics**					
Crisps						**Alcohol**					
Nuts						**Cigarettes**					
Sugar						**Drugs (illegal)**					

Do you eat regular meals? Yes__ No__ **Do you eat in a hurry?** Yes__ No__

Please Note:

Client Records are taken for the purposes of giving the best Service to clients. They are always Kept on File in a Locked Filing Cabinet in the Consultation Room which is also Locked when not in use. Keys are kept safely by the designated person at all times.

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List the foods you eat:		
Morning	**Afternoon**	**Evening**

Energy Levels through the day – Please Circle:	1 = Exhausted				10 = Jumping over the moon					
Morning	1	2	3	4	5	6	7	8	9	10
Afternoon	1	2	3	4	5	6	7	8	9	10
Evening	1	2	3	4	5	6	7	8	9	10

I have discomfort after eating: Yes ___ No___
I am concerned/worried at present: Yes__ No___
I do the following forms of Exercise: _____
I walk/run/cycle in day light: No__ Yes__ How often? _____

I have natural light in my work space: Yes__ No__
I use a computer: No__ Yes___ **Daily usage**: ____Hours _____ Minutes
I use a mobile phone: No___ Yes___ **Daily usage**: ____Hours _____ Minutes
Stresses at work: _____
I am Happy at Work: Yes__ No__ **My job is fulfilling:** Yes__ No__
Stresses at Home: _____
My Ability to relax is: Good___ Poor___ **My Work/Life Balance is:** Good __ Poor__
My sleeping pattern is: Good___ Poor___ **Hours of unbroken sleep each night**: _____ (you do not wake)
When I wake in the morning I feel: Refreshed__ Tired__ Dry Mouth ___
Generally speaking my mouth is: Dry__ Bad Taste ___ Smelly Breath ___ Okay___

My reasons for attending / briefly give a picture of what is going on for you right now – signs and symptoms …:
_____

Other Information I wish to offer at this time:
_____
_____
_____

Clients consent:

☐ I have filled this form to the best of my ability and know of no reason why I cannot avail of the services offered.

☐ I understand that Complementary Therapies help my body to help itself find balance - there are no 'cures'. I am also aware that on occasion I may experience a 'Healing Process' - this is a natural process of healing and balancing that can happen. I will not hold the Practitioner responsible for any such experiences I may have following treatments.

☐ I give permission for you to hold my records in order to deliver your services for the duration of my visits and for up to five/seven years thereafter as per instructions of the relevant Professional and State Bodies. I understand that all notes will be kept filed in a locked cabinet in a locked room and the key will be kept by the designated member of staff.
(Please understand that if you decline to give the above permissions we will not be able to deliver any services to you)

☐ I give permission to use this information for marketing purposes such as special offers and health information
(This is completely voluntary. This will not affect how we treat you)

☐ In case of emergency I give you permission to contact the person named below and take full responsibility to tell them I have shared their contact details with you to keep on file.
Name: _____ Relationship to me: _____ Tel: _____

Client's signature: _____ Date: _____

Doctor's/Consultant's Approval (if needed)
I am happy that my patient avails of Complementary Therapy Services offered at Kinesiology4u.ie and know of no reason why it may affect his/her Medical Treatment.

Doctor's Signature:_____ Date:_____

Services Currently Offered @Kinesiology4u: Kinesiology, Stress Management, Two Meridian Tapping, Energy EFT, Matrix Reimprinting Using EFT, Energy Coning Technique, Reflexology, Hopi Ear Candling, Integrated Energy Therapy, Sacred Circle Dancing

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