Office use: ☐ CP ☐ X ☐ M

NEW CLIENT REGISTRATION FORM

CONTACT DETAILS	
Name:	**Date:**
Phone:	Email:
Would you like to be on the database to receive weekly emails about a variety of health topics? ☐ Yes ☐ No	
Address:	
Postcode:	DOB: Age:
Children (no. & ages):	Siblings (no. & ages):
Occupation/School:	Part-time/Full-time/School Year:
Emergency contact (name, relationship & ph. no.):	
Who may I thank for referring you or where did you find my details?	

What is your primary health concern? (it may be physical, mental or emotional)

When & how did it start?

What relieves your symptoms?

What makes your symptoms worse?

Have you received/are you receiving any other care for this issue? Yes ☐ No ☐
If yes, please describe:

What would you like to achieve from Kinesiology?

Office use only - please turn over

For the remainder of the form please tick/highlight relevant issues and provide brief information where requested. We will go into them in more detail during your appointment.

1. STRUCTURAL

- Headaches/Migraines
- Neck pain
- Shoulder tension
- Back pain
- Chest pain
- Jaw pain/grinding teeth
- Joint pain
- Scar tissue

List any broken bones and the age they occurred.

List any accidents such as car accidents or falls which resulted in injury/whiplash and age they occurred:

List all operations you have had and the age they occurred:

2. ELECTRICAL

- Dyslexia or Dyspraxia
- letter/number reversal
- handwriting
- reading comprehension
- lose place when reading
- eyes red, burning, itching when reading
- hand-eye coordination
- slow in completing work
- Noise/light sensitivity
- Can't sit still
- Clumsy/uncoordinated

3. EMOTIONAL/MENTAL

- Anxiety
- Depression
- Stress management
- Disordered eating (current or past)
- Phobias
- Healing past traumas

Briefly list past emotional traumas that you feel are still affecting you today with age of occurrence.

4. ECOLOGICAL

- Menstrual cycle – Please circle: Heavy bleeding, irregular monthly cycle, long bleeding, mood, other
- Allergies (food or other)
- Thyroid imbalance
- Other hormonal issues
- Blood pressure
- Digestion
- Urinary issues
- Dark circles under eyes
- Muscle cramps
- Eye/mouth twitches
- Skin issues
- Nail issues
- Hair issues
- Vaccination reactions

4a. Nutrition & Lifestyle:

Preferred diet I eat anything Vegetarian/Vegan Other

How much water do you drink per day?

How much coffee/black tea do you drink per day?

Do you drink cordials, soft drinks or pre-packaged juices? Yes No

Please list other drinks you have on a regular basis:

Do you eat breakfast? Yes No

How many meals & snacks do you eat per day?
Do you have cravings for: □ Sweet □ Savoury □ Other
Do you drink alcohol? □ Yes □ No If yes how many standard drinks per week?
Do you smoke? □ Yes □ No If yes how many cigarettes per day?
Do you exercise regularly? □ Yes □ No If yes, please list type, duration & frequency:

Who does most of the cooking in your house?

4b. Digestion:
How many bowel motions do you have per day? □ <1 □ 1 □ 2-3 □ >3
Do you have any of the following issues regularly?
□ Constipation
□ Loose bowel motions/diarrhoea
□ Feeling of incomplete bowel motion
□ Strong smell
□ Bloating/distention
□ Abdominal pain
□ Burping (excessive)
□ Wind (excessive)
□ Indigestion/Reflux
□ Other, please specify:

4c. Urinary System:
What colour is your urine usually? □ Clear □ Pale □ Bright □ Dark □ Red
Do you have any of the following issues?
□ Frequent urination
□ Excessive thirst
□ Cloudy urine
□ Frothy urine
□ Painful urination or recurrent UTIs
□ Incontinence

5. CHILDHOOD
Were there any issues when your mother was pregnant with you? If yes, please describe:

Issues with your birth: □ premature □ caesarean □ forceps □ Other
Were you breastfed, bottle fed or both? □ breastfed □ bottle fed □ both
Milestones – were there any issues with: □ crawling □ walking □ talking
Did you have any of the following severe or recurring illnesses as a child?
□ Tonsilitis/sinusitis/ear infections
□ Measles/Mumps/Chickenpox
□ Glandular fever
□ Severe gastroenteritis
□ Colic
□ Reflux
□ Constipation/digestion issues
□ Other, please specify:

6. GENERAL:
□ Sleep
□ Energy

7. CHILDREN ONLY:
□ Bedwetting
□ Defiant
□ Hard to discipline
□ Needy/clingy
□ Overactive
□ Underactive

8. FAMILY HISTORY - Are there any medical conditions in your family (immediate & extended)?
□ Cancer
□ Type II Diabetes
□ High blood pressure
□ Heart disease
□ Stroke
□ Arthritis
□ Osteoporosis
□ Mental health issues
□ Autoimmune disease
□ Other, please specify: