CONFIDENTIAL CLIENT QUESTIONNAIRE

PERSONAL DETAILS

Name: Date:

Address:

State: Postcode: Email:

Phone: H M

Date of Birth: Age:

Occupation:

Marital Status: No. of Children:

Who referred you: Current GP:

Would you like to be included in my mailing list (please circle): Yes No

PRESENTING CONCERNS

WHAT WOULD YOU LIKE TO ACHIEVE FROM THE SESSION?

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HEALTH HISTORY

Please √ any of the following conditions that you are currently experiencing or have experienced in the last 6 months.

☐ Back pain	☐ Dizziness	☐ Asthma
☐ Dyslexia	☐ Ringing in ears	☐ Regular colds/flu
☐ Neck pain	☐ Nervous/anxiety	☐ High blood pressure
☐ Headaches	☐ Difficulty sleeping	☐ Low blood pressure
☐ Tired/fatigue	☐ Allergies	☐ Chest pain
☐ Tension in body	☐ Digestive problems	☐ Heart condition
☐ Numb/tingling in arm/hand	☐ Diarrhoea	☐ Epilepsy
☐ Numb/tingling in leg/foot	☐ Constipation	☐ Diabetes
☐ Muscle cramps/sprains	☐ Weight problems	☐ Depression

LIFE STYLE & FAMILY HISTORY

Illness:

Surgeries:

Current Pain: Severity:

Current Medication: Supplements:

Water Intake: Sleep:

Exercise: Bowel Movements:

Relaxation: Hobbies:

Energy Level: Addictions:

Family History:

INFORMED CONSENT & DISCLAIMER

Informed Consent

I declare that the above information is true and correct and indemnify Ozsoul Healing (the clinic) of any liability for any false or misleading statements given. It is understood and accepted that the treatment received by the clinic is of remedial therapeutic nature and not of a diagnostic/curative approach. It is also understood and accepted that the results of the treatment are not guaranteed in any way and that any data or notes taken during the sessions will remain the property of the clinic as part of the case history records. In addition, I understand that a copy of any kept personal records will be made available to me within 48 business hours of my request at any such time and that my personal information, unless otherwise noted by me, may be used by the clinic for notification of any future news, products or services as deemed appropriate by the clinic. I am attending the clinic of my own free will and consent and exercise my right to discuss and choose any suitable treatments available to me.

I further understand that no account is rendered by the clinic and payment less any deposit will be made at the time of the service and can be either by cash or credit card. I understand and accept the cancellation policy of the clinic is 48 hours' notice and should this not be adhered to a cancellation fee may be charged.

Disclaimer

I understand that Applied Physiology & Kinesiology practitioners do no diagnose illness, disease or any other physical or mental disorder, nor do they prescribe medical treatment of any kind. I acknowledge that Applied Physiology & Kinesiology is not a substitute for a medical examination, diagnosis or treatment and that it is recommended that I see a medical practitioner for these services.

Name (BLOCK CAPITALS):

Signature (Parent or Guardian if under 18):

Date:

M 0413 541 902

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https://ozsoulhealing.com.au/