Align Nourish Hydrate Restore

Client Intake

Name……..……M/F Date……..……

Date of Birth…….……Mobile:…….……..…

Address……

……..……

Email:……

Emergency Contact: (name & ph: no:) ……..……..

Additional information regarding your family background and current situation/lifestyle assists in providing a greater understanding to obtain a meaningful outcome to your session.

Relationship Status: Single | Partner | DeFacto | Married | Divorced | Widowed | Other

Significant Other: Name & Age……

Children? Names & Ages……

Family Background: Siblings: Y/N | Name & Ages: sibling order oldest to youngest, including yourself

……

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Parents: Married | Divorced/separated | Re-partnered |Deceased | Other

How would you describe your relationship with your:(complete below)

Mother:……Father:……

Which of the following best describes your current situation?

Study Full/Part Time |Employed Full/Part Time | Sole Trader | Business Owner | Full time Carer | Retired | Other……

Occupation:……

Lifestyle:

What is your current **energy level**? 0 =Low 10 = High ……/10

What is your current **stress level**? Low | Medium | High

Sleep: bedtime:……waking:…… restless | deep | light | woken up

Do you wake during the night? rarely | occasionally | often – time……

Do you find it difficult to fall asleep? Y/N ……..

Do you feel refreshed in the morning? ……..

How often do you **exercise**? Daily | twice a week | 3 or more x a week | occasionally | never If yes: what type of exercise do you prefer?.....

How do you manage your **stress**? Relaxation | meditation | activities | other……..

Dietary habits: please tick your preferences

☐ meat & veg	☐ dairy free	☐ coffee ……a day
☐ vegetarian	☐ sugar free	☐ tea……a day
☐ vegan	☐ gluten free	☐ soft drink…….a day
☐ take away	☐ wheat free	☐ water …….L a day
☐ fresh food	☐ eating out	☐ processed snacks
☐ sugar/sweet foods	☐ salty food	☐ carbs potato/pasta/rice/noodles

☐ alcohol……day/week/month/occasionally wine/beer/spirits

☐ food intolerances?.....

☐ supplements?.....

Are your **bowel** movements regularly? Daily | 3 x a week | weekly | other……..

If you are **female**: Are you pregnant? No | Yes Due date:……..

Are you trying to conceive? Y/N Do you use contraception? Which one? ……..

Is your cycle: regular | heavy | painful | menopausal symptoms | irregular | light

Please tick any of the following you consider a stress in your life, either past or present:

PAST PRESENT

- ☐ ☐ Anger Issues
- ☐ ☐ Anxiety
- ☐ ☐ Back Pain L M U
- ☐ ☐ Children/Parenting
- ☐ ☐ Communication
- ☐ ☐ Concentration
- ☐ ☐ Constipation
- ☐ ☐ Depressive thoughts or tendencies
- ☐ ☐ Diarrhoea/IBS
- ☐ ☐ Divorce/Separation
- ☐ ☐ Dizziness/Vertigo
- ☐ ☐ Education / Study
- ☐ ☐ Fatigue/Tired
- ☐ ☐ Fear of …………………..

PAST PRESENT

- ☐ ☐ Financial Stress
- ☐ ☐ Friendships
- ☐ ☐ Grief relating to……
- ☐ ☐ Headaches
- ☐ ☐ Heart problems
- ☐ ☐ Herpes/ Cold sores
- ☐ ☐ High/low blood pressure
- ☐ ☐ Incontinence
- ☐ ☐ Jaw issues/ TMJ symptoms
- ☐ ☐ Lacking energy
- ☐ ☐ Relationship issues
- ☐ ☐ Migraines
- ☐ ☐ Mood swings
- ☐ ☐ Motivation (lack of)

PAST PRESENT

- ☐ ☐ Neck pain/tension
- ☐ ☐ Pain in the body
- ☐ ☐ Poor Circulation
- ☐ ☐ Regular colds/flu
- ☐ ☐ Relaxation difficulties
- ☐ ☐ Repetitive thinking
- ☐ ☐ Self-control
- ☐ ☐ Self-esteem
- ☐ ☐ Shyness/timid
- ☐ ☐ Skin problems
- ☐ ☐ Sleeping problems
- ☐ ☐ Trust issues
- ☐ ☐ Unhappiness
- ☐ ☐ Weight under/over

What is your **reason** for being here today? What would you like to work on in your session and what are you **hoping to achieve** from your session today?

……..……………………………………………………..……………………………………………..

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I declare the above information to be **true and correct** and indemnify Blue Sky Healing of any liability for any false or misleading information given. It is understood and accepted that the session provided by Blue Sky Healing is of a **therapeutic nature** and **not diagnostic** and does not offer a curative approach and **results are not guaranteed** in any way. All information gathered regarding clients will remain the property of Blue Sky Healing and will be remain **confidentially secured**. Information may be used for **notification of events and services** as deemed appropriate. I agree that **payment for services** be made at the time of service to be made by cash, credit card or bank transfer. I agree to provide **24 hours' notice of cancellation**. I hereby give Jenny Fitzgerald **permission to conduct Kinesiology** on me.

Signed:…………………………………………………………………Date:…………………………..


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Healing
Bowen Therapy
Kinesiology
Intuitive Healing
Reiki