Mind & Motion Kinesiology
Client Information Sheet

(All information Confidential)

Name: ---------- Date: ----------

Address: ---------- Postcode: ----------

Email address: ----------

Phone numbers: Home: ---------- Mobile: ----------

Date of Birth: ---------- Country of Birth: ----------

Marital Status: Single/ Married/ De-facto/ Widowed/ Separated/ Divorced (please circle)

Next of Kin, name and contact number:

Do you have children? ---------- If yes how many? ----------

Occupation: ----------

Who referred you? ----------

Please briefly describe what you would like to get out of our session today: ----------

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What other forms of therapy have you used to resolve your health problem(s)? ----------

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How successful were they? ☐Very successful ☐partly successful ☐not successful

What do you think lies at the root of your symptoms?

Please briefly explain any relevant issues or challenges with the following:

Bowel movements: ☐daily ☐less than daily
Hard to pass, Firm and easy to clean up after, Fluffy, undigested food in stools, runny, alternates between constipation and diarrhoea, constipation, diarrhoea. (Please circle)
Menstrual Cycle: regular/irregular, painful, heavy/light, menopausal, PMS, Moody, emotional, anger, ovulation pain (please circle)
Digestion: any problems, bloating, gas, reflux, burping?
Sleep: falling asleep, staying asleep, waking to urinate
Pain: Do you experience back pain, neck pain or other physical pain?
Skin: dry skin, sweating profusely
Posture: any postural issues diagnosed, scoliosis, lordosis, kyphosis
Mentals: main emotions displayed under stress -
Headaches: if so what is the pain like, sharp, stabbing, fixed, or dull ache? What part of the head do they present in?
Eyes: any issues with eyes, dryness, itching, dry upon waking, loose focus often?
Ears: any earaches, ringing in the ears (if so loud or soft?)
Nose: Nasal congestion? Sinus? If so, with mucus or without?
Face: numbness, tingling
Mouth: ulcers, cold sores – if so how often
Throat: feel like something stuck in throat – if so any phlegm or not?
Respiration: any problems breathing, in or out? If Asthmatic please advise problems breathing in or out
Urination: any problems with urination, urinary tract infections, etc.?
Back and extremities – any pain? If so pain type, fixed, stabbing, dull ache
Memory: poor memory or good memory
Foggy head:
Stress levels: 1-10 (1 being no stress at all, 10 being highly stressed)
Energy levels: 1-10 (1 being no energy at all, 10 being high energy)
When is your energy at its lowest?

Do you feel Hot at night? Prefer cold or hot drinks? Do you feel the cold?

If you are female: Are you pregnant? ---------- *If yes how advanced?* ----------

Do I have permission to contact your Doctor?_____

Doctors Name: _____Phone Number: _____

Legal Information: By signing below I agree to the following terms of my treatment:

All information provided on this intake form is for the purpose of gathering information specific to you, so I can tailor a plan that will be most helpful to your wellbeing.

Mind & Motion Kinesiology of 32 Daisy Street, Dee Why, NSW 2099 will collect and store the information you voluntarily provide to enable effective treatment in session. The information will be provided to relevant staff and be provided to medical professionals where necessary. You consent to these disclosures. Any information provided by you will be stored on a database that will only be accessed by authorised personnel and is subject to privacy restrictions. The information will only be used for the purpose for which it was collected. Any information provided by you to Mind & Motion Kinesiology can be accessed by you during standard office hours and updated by writing to us or by contacting us on 0418 722 429.

Please agree, that you have compiled this information to the best of your knowledge. You understand that Holistic Kinesiology, Mind Body Medicine and Sport Therapy is a health aid and in no way to take the place of Doctors care when it is indicated. Information exchanged during any session is educational in nature and is intended to assist me become more familiar and conscious of your own health and is to be used at my own discretion.

I understand that if I am referred to see a Doctor, by Employees of Mind & Motion Kinesiology that I will take responsibility to do so and will attend an appointment to get a professional opinion.

Cancellation Policy: The appointment time reserved for you is exclusively for you. We require a 24 - hour notice of cancellation. If you must cancel, or reschedule, an appointment due to an emergency, please notify us as soon as possible, we understand that things do happen. If you do cancel with less than 24 hour's notice, 50% payment for the session is required. Thank you for your consideration and understanding.

Lateness Policy: lateness of more than 15 minutes results in cancellation of appointment, unless otherwise agreed upon.

No Show: In the event of a no call/no show situation, in addition to Cancellation/Lateness Policies, the client will be charged for the full session cost.

Signed: ……

Date: ……

Aetiology (motivator – behaviour – pattern):