Stephanie Einhorn
Dip. Holistic Kinesiology
Bachelor of Science (UWA)
ATMS Member

Holistic kinesiology – Client history

Date ___________

Name _________________________________ Gender M F

Date of birth ____________________________

Phone _________________________________

Email ____

Address ____

____

Health Insurance _____________________________

Occupation _________________________________

Marital status ________________________________

Children (names and ages)

____

Pregnant __________

How did you hear about me? ________________________

Would you like to receive a monthly newsletter? Yes No

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steph@thewellnessweb.com.au www.thewellnessweb.com.au

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Health history-

Heart conditions

Hypertension (High blood pressure)

Asthma

Allergies (food/ medications/ environmental)

Psychological disorders

Neurological disorders

Joint/muscular pain and injury

Side effects from other treatments

Fainting

Epilepsy

Blood type (If known)

Vaccinations (which ones)

Amalgam fillings

Contraceptive pill (which one)

How long have you been on the pill or when did you come off:

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Current pharmaceutical medication/ nutritional supplements/ herbal medicine

____

____

____

____

Current and previous illnesses/ accidents/ surgery (please indicate details and date)

____

____

____

____

____

Have you seen or are you currently seeing any other health practitioners?

Sleep pattern-

Hours per night _________

Difficulty falling asleep? _____________

Do you wake during the night? What time usually? ______________

Do you urinate at night? ____________________

Sleep quality- light/ average/ heavy ____________________

Awake- refreshed/ tired ______________

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Energy levels-

Rate from 1- 10 (1 being low; 10 being high) ____________

Energy slumps? What time of the day? _____________

Stress levels-

Rate from 1- 10 (1 being low; 10 being high) ____________

Current source of stress

Exercise (Type and frequency)

Menstrual Cycle (days of cycle/ days of bleed/ consistency, colour of blood/ clots, PMS symptoms)

Diet (Any specific dietary needs)

Typical daily intake of water (details of other fluids including juice/ cordial)

Typical daily intake of Coffee/ Tea

Typical daily/ weekly intake of Alcohol

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Food/ beverage cravings

Foods/ beverages that cause discomfort

Bowel movements and digestion (How often, stool consistency/ colour)

What is the reason for your kinesiology session?

____

____

How are you feeling right now?

____

____

____

Ideally, how do you want to feel after the session? (3 words)

____

____

____

What are your goals?
What are you hoping to get out of your kinesiology sessions?

____

____

____

____

Is there anything else you'd like me to know?

____

____

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