Stephanie Herscovitz
Dip. Holistic Kinesiology
Bachelor of Science (UWA)
ATMS member

Steph Herscovitz
Holistic Kinesiology - Children's client history

Date:

Parents name:

Childs name: **Gender: M F**

Date of birth:

Telephone:

Email:

Address:

Siblings:

School:

Health insurance:

How did you hear about me?

What other practitioners have you seen or are you currently seeing?

Vaccinations:

Allergies (food/medications/environmental):

Asthma:

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Previous accidents/illness/surgery:

Side effects from other treatments:

Presenting issues/symptoms:

When did you start to notice something different?

How does it affect their daily life?
(reading/writing/playing/school)

Special diet choices/needs:

Has your child taken antibiotics before? (If so, roughly how many times?)

Sleep patterns or problems:

Energy levels during the day on a scale of 1-10:

Bowel movements-
How often? Any pain/discomfort?

Supplements and medication:

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Was your child born early/late/on time?

Did your child have a natural birth?

Was it an unusually fast or slow birth?

**Did you have any complications during your pregnancy?
(Limited movement in the last few months etc)**

Was your child breast-fed?

Did your child crawl?

In general, what were they like as a baby?

Any other relevant information:

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