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Bachelor of Science (UWA)
ATMS Member

Stephanie Herscovitz
Holistic Kinesiology - Children's client history

Date:

Parents name:

Childs name: **Gender: M** ☐ **F** ☐

Date of birth:

Telephone:

Email:

Address:

Siblings:

School and teachers name:

Referred by:

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

Allergies (food/medications/environmental):

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Asthma: ☐

Previous accidents/illness/surgery:

Side effects from other treatments:

Presenting issues/symptoms:

When did you start to notice something different or a change?

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

How are their relationships at school, with friends, siblings, father and other family?

Special diet choices/needs:

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Typical daily diet (breakfast, lunch, dinner, snacks and water):

Sleep patterns or problems:

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

Bowel movements and digestion-
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 your child breast-fed?

Did your child crawl and for how long?

Any other relevant information: