International Institute of Kinesiology Australia

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CONFIDENTIAL CLIENT QUESTIONNAIRE

PERSONAL DETAILS

Name:_____ **Date:**____/____/____

Address:_____

State:_____ **Postcode:**_____**Email:**_____

Phone (H)_____ **(W)**_____ **(Mb)**_____

Date of birth:_____/_____/_____ **Age:**_____ **Sex: M/F**_____

No of siblings (name age gender): _____

Occupation:_____ **Marital Stutus:** _____

Spouse/Partner (name, age):_____ **No. of Children:** _____

Children (name, age, gender):_____

Private Health Fund:_____

You were referred by:_____ **Current Medical Doctor**_____

Other health professionals_____

REASONS WHY YOU ARE HERE

_____
_____
_____
_____
_____
_____
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_____
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HEALTH HISTORY

Please √ any of the following conditions that you are currently experiencing or have experienced in the last 6 months.

☐ Lower back pain	☐ Dizziness	☐ Asthma
☐ Upper/mid back pain	☐ Ringing in ears	☐ Regular colds/flu
☐ Neck pain	☐ Nervous/anxiety	☐ High blood pressure
☐ Headaches	☐ Difficulty sleeping	☐ Low blood pressure
☐ Tired / fatigue	☐ Allergies	☐ Chest pain
☐ Tension in body	☐ Digestive problems	☐ Heart condition
☐ Numb/tingling in arms/hands	☐ Diarrhea	☐ Epilepsy
☐ Numb/tingling in legs/feet	☐ Constipation	☐ Diabetes
☐ Muscle cramps/sprains	☐ Weight problems	☐ Depression

Other conditions _____
_____
_____
_____

Which of the above conditions is the worst _____
_____
_____

Describe severity of the condition _____
_____
_____

What treatments have you tried prior to today_____
_____
_____

List all surgery you have had and at what age _____
_____
_____
_____

List all major fractures, falls, head injuries or accidents over the last 10 years _____

_____

_____

Have you had any major dental work: _____

List any other previous illness that has not been mentioned above_____
_____

_____

_____

Are you pregnant or is there any possibility that you are pregnant_____

If applicable, how many weeks: _____

LIFE STYLE

How many hours do you sleep each night _____ Time you retire _____ Time you rise ___

How often do you exercise ☐ Daily ☐ Twice or more daily ☐ Weekly ☐ Never

If applicable, what exercise do you do and the duration
_____

Do you have a daily bowel movement: Y/N_____
_____

_____

_____

Do you smoke Y/N _____ Number per day _____ How long have you smoked _____

What drugs (medical or recreational) are you currently taking (include dosage & duration)
_____

_____

_____

What vitamin or mineral supplements are you currently taking (include dosage) _____
_____

_____

_____

Do you have any food sensitivities/allergies:_____

Indicate your normal/general diet:

☐ Meat & 3 veg ☐ Vegetarian ☐ Vegan ☐ High protein ☐ Macro

☐ Wheat free ☐ Gluten free ☐ Diary Free ☐ Other _____

Daily intakes of:

Sugar _____ Coffee _____ Tea _____ Alcohol _____ Water (ltr)_____

Additional diet information _____

_____

_

FAMILY HISTORY

Please give brief details of any health problems in your family history i.e. great grandparents, grandparents, parents, children, cousins etc

Relation Current and/or past health problems

_____

_____

_____

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INFORMED CONSENT

I declare that the above information is true and correct and indemnify your clinic of any liability for any false or misleading statements given. It is understood and accepted that the treatment received by your clinic is of remedial therapeutic nature and not of a diagnostic/curative approach. It is also understood and accepted that the results of the treatment are not guaranteed in any way and that any data or notes taken during the sessions will remain the property of your clinic as part of the case history records. In addition, I understand that a copy of any kept personal records will be made available to me within 48 business hours of my request at any such time and that my personal information, unless otherwise noted by me, may be used by your clinic for notification of any future news, products or services as deemed appropriate by your clinic. I am attending your clinic of my own free will and consent and exercise my right to discuss and choose any suitable treatments available to me.

I further understand that no account is rendered by your clinic and my payment is at the time of the service and can be made either by cash or cheque. I understand and accept the cancellation policy of your clinic is 48 hours notice with a cancellation fee of $120 to be paid if due notice is not given.

Patients Signature (parent or guardian):_____

Patients Name: _____

Date: _____/_____/_____