WISE KINESIOLOGY
EMPOWER.CONNECT.RESTORE

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Confidential Client History Form

Name: _____ Date of Birth: _____

Email: _____ Phone: _____

Occupation: _____

Marital status: _____Children:_____

Pregnant: No / Yes_____If yes, how many weeks? _____

Next of kin: _____Phone: _____

Who shall we thank for the referral? _____

Chief complaint / Presenting issues: _____

_____

_____

How long have you had it for? What do you think is causing it? _____

_____

Setting in which it occurs:_____

Timing (if the complaint occurs at a specific time of day): _____

Frequency (how often they feel this way): _____

Duration (how long each episode lasts): _____

Quantity and Severity (rate 0/10): _____

Aggravating or relieving factors: _____

How will you know if the above are improving? _____

In what time frame do you expect this to happen? _____

What would you like to change in your life/ have more or less of: _____

_____

_____

What is your expectation of the session outcome? _____

_____

Psychological/ Mental Stress – emotions (e.g. fears, anger etc), relationships (family, partner etc), job stress:

_____

_____

_____

Do you overthink/ worry a lot? Get angry easily/ criticise yourself?_____

_____

How do you feel about self-confidence / confrontation / criticism /company / anger / security? _____

_____

Any history of:

Allergies / Allergic reactions: _____
Previous illnesses / accidents / surgery (please indicate date and year): _____
_____
_____
Headaches (sides/ top/ front/ behind eyes)? Migraine? How often? Does it relate to anything? _____
_____
Acute/chronic pain in the body? _____
Digestive system (undigested food in the stool, bloating, reflux, flatulence, gut issues)?_____
_____
Bowel movements (how many a day/week, soft/hard, constipation/diarrhea)?_____
_____
Heart problems, blood pressure?_____
Breathing/ lung problems? _____
Immunity/frequent colds? _____
Back problems/knees? _____
Skin/nails/teeth Issues? _____
Hormonal problems (thyroid, adrenals, diabetes)? _____
Reproductive/fertility?_____
Feel mostly cold/hot (feet/hands)?_____
Current/past medications / supplements / vitamins: _____
_____
_____

Lifestyle, Sleep and Energy:

How many hours of sleep do you get per night? Do you sleep lightly / averagely / heavily? _____
Do you find it difficult to fall asleep? If yes why? _____
Do you wake up during the night? If yes, at a particular time? _____
Do you need to urinate during the night? If yes, how many times?_____
Is it easy to fall back to sleep once you are awake? Yes / No_____
Do you have dreams/ nightmares? _____
Do you wake felling tired or refreshed (first 10-60 min)? _____
Energy Levels (rate from 1 to 10, 10 being high): _____
Energy slumps during the day? If yes, at a particular time? _____
Exercise (type, frequency, intensity)? _____

Diet and Nutrition:

Special dietary requirements? _____
Food cravings? / Prefer hot or cold food? Hot or cold drinks?_____
_____
Water intake: _____ glasses / litres per day
Coffee intake:_____ cups per day / week
Alcohol intake: _____ stand. drinks per week
Cigarettes: _____ per day / week
Drugs (type): _____ per day/week/month

Please provide an overview of your current diet (one day):_____
_____
_____