CLIENT HISTORY FORM

This is a confidential record all personal information is kept in strict confidence and not shared with any other party without your consent.

Name: _____ Surname: _____
Address: _____
Suburb: _____ Postal Code: _____
Contact Number: _____ Email: _____
Birthdate: _____ Age: _____

Marital Status: _____ Children: _____
Occupation: _____

Referred By: _____

Are you seeing any other health professional and if so, what for:

_____
_____
_____
_____

Current drugs or medication (prescription or recreational):

_____
_____
_____
_____

Current supplements:

_____
_____
_____
_____

Past accidents/operations (include date and age):

□ Back injury	□ Broken bones	□ Brain injury
□ Head injury	□ Internal organ injury	□ Muscular injury
□ Neck injury	□ Skeletal injury	□ Torn ligaments/tendons
□ Other: _____	□ Other: _____	□ Other: _____

□ Back surgery	□ Blood transfusion	□ Brain surgery
□ Head injury	□ Internal organ surgery	□ Ligament/tendon repair
□ Mastectomy	□ Muscular surgery	□ Neck surgery
□ Organ removal	□ Skeletal surgery	□ Reconstructive surgery
□ Other: _____	□ Other: _____	□ Other: _____

_____
_____
_____
_____

Please check if you have experienced any of the below conditions:

□ ADD	□ ADHD	□ Allergy/ies
□ Anemia	□ Anxiety	□ Asthma
□ Autism	□ Back pain	□ Bronchitis
□ Blood Pressure – High	□ Blood Pressure – Low	□ Bleeding
□ Candida	□ Chest pain	□ Cholesterol
□ Constipation	□ Croup	□ Depression
□ Diabetes	□ Diarrhea	□ Dizziness
□ Eczema	□ Epilepsy	□ Fatigue
□ Food Intolerance/s	□ Gingivitis	□ Hay fever
□ Headache/s	□ Heart burn	□ Heart complaints
□ Hepatitis A, B or C	□ Hernia	□ HIV/AIDS
□ Hot Flushes	□ Insomnia	□ Itching / rash
□ Jaundice	□ Low blood sugar	□ Low grade fever
□ Malignant Melanoma	□ Menstrual cramps	□ Migraine/s
□ Muscle Cramps	□ Nausea	□ Neck pain
□ Numbness or tingling	□ Osteoporosis	□ Pain / inflammation
□ Palpitations	□ Panic Attacks	□ Pregnancy
□ Pneumonia	□ Regular colds or flu	□ Rheumatoid Arthritis
□ Rheumatic Fever	□ Ringing in ears	□ Shortness of breath
□ Sleeping difficulty	□ Swollen glands	□ Tonsillitis
□ Urinary/genital	□ Vomiting	□ Weight – gain
□ Weight – loss	□ Vaccinated?_____	Other? ____

Do you smoke? □ No □ Yes Number per day or week? _____
Do you drink alcohol? □ No □ Yes Number per day or week? _____
Do you exercise? □ No □ Yes How many times a week? _____
Do you drink water? □ No □ Yes How many glasses a day? _____

Please give brief details of any familial health problems:

Relation Current or past health conditions

_____
_____
_____
_____
_____

Please list any details you know about your birth and/or the birth of your children (i.e. natural childbirth, caesarean, premature, forceps, induced, incubation etc.):

_____
_____
_____
_____
_____

Please describe your family dynamics (i.e. sibling order, relationship between parents, siblings, children, etc.):

_____
_____
_____
_____
_____

Emotional trauma (include date and age):

_____
_____
_____
_____
_____

Do you have or have you ever had silver (amalgam) fillings in your teeth?_____
_____
_____
_____
_____
_____
_____

What do you want to have happen as an outcome of this session and future sessions?

_____
_____
_____
_____
_____
_____

Reason why you are here today:

_

CONSENT FORM

I,.....
(name of client or, in the case of a minor, parent/guardian) hereby acknowledge that, before consulting with me, **Lynn Angel**, made it clear to me that she works in accordance with the terms and conditions of the Code of Ethics and Member's Code of the Association of Specialised Kinesiologists, South Africa, as displayed in the practice rooms.

Furthermore, I acknowledge that she:

- Does not diagnose or treat a named disease,
- Does not have the authority to take me off any prescribed medication,
- May suggest that specific nutrition or essences may be advantageous for me to take – however the decision on whether to follow her advice is entirely my own.

I have been advised that neither the Association of Specialised Kinesiologists, nor it's individual members nor, **Lynn Angel**, will be legally liable or responsible for any risk of illness, injury or aggravation of any medical condition whatsoever that may arise out of the consultation with me, and arising out of my failure to consult with and obtain approval from a registered medical doctor prior to commencing sessions with **Lynn Angel**. I hereby consent to such consultation and indemnify the Association, its members and **Lynn Angel** against any and all claims by myself, my successors and assign in this regard.

Please note that appointments cancelled 24 hours in advance will not be charged for.

_____ _____

Signature of client or parent/guardian Date