**SWAHA KINESIOLOGY CLIENT FORM**

DATE:

Start Time: End Time:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **First Name** |  | | **Surname** |  | | **DOB** |  |
| **Address** |  | | **Suburb** |  | | **Postcode** |  |
| **Occupation** |  | | **Email** |  | | | |
| **Mobile** |  | **Work** |  | | **Gender** | **M ☐** **F ☐** **Other ☐** | |

|  |
| --- |
| **I found out about kinesiology through: Friend ☐ Internet ☐** **Flyer ☐** **Other ☐** describe: |

|  |  |  |
| --- | --- | --- |
| Presenting challenge/s  requiring assistance: |  | **Practitioner Notes:** |
| Medical and health background: |  |  |
| Current conditions: |  |  |
| List any surgeries: |  |  |
| Medications: |  |  |
| Supplements: |  |  |
| Emotional Issues: |  |  |
| Relationship / social issues: |  |  |
| Financial Issues: |  |  |
| Other: |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you have any internal devices such as a pacemaker or are you pregnant?**  If yes, describe: | Yes **☐** No **☐** | **Do you have any special needs?**  If yes describe: | Yes **☐** No **☐** |
| **Do you have any learning challenges?**  If yes describe: | Yes **☐** No **☐** | **Are you receiving, or have you previously received, support from other therapies/practitioners for the presenting challenges or current conditions?**  If yes, describe: | Yes **☐** No **☐** |
| **Do you have any medical test results or referral information?**  If yes, include with this form. | Yes **☐** No **☐** | **Are you willing to receive an occasional email from Swaha Kinesiology?** including any upcoming specials, handy stress reduction tips etc | Yes **☐** No **☐** |

**Client Declaration:**

I have disclosed the above personal information for the purpose of a kinesiology consultation. I accept full responsibility for all consultations. I agree to cancel appointments for myself or my child with at least 24 hours prior notice; otherwise I am liable for 25% of the consultation fee. If I fail to show up for an appointment then I am liable for the full fee of the consultation.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_