

Harmony Kinesiology Questionnaire

1st Session Date _____

Please Note: This questionnaire has been designed to provide information to assist us in determining how we can help you. Please answer all the questions as accurately as possible. All information is confidential. If you need more space to answer any question, please continue on the back of the page.

Name _____ **Date of Birth** _____ **E-mail** _____

(including first name and preferred form of address: Ms/Miss/etc)

Address _____

Post Code _____ **Phone No (Day)** _____ **Phone No (Eve)** _____

Referred by _____ **Mobile Phone No** _____

Health Background:

Present state of health _____

Present Doctor _____ **Phone No** _____

Present Treatment (including drugs and supplements)

Lifestyle

Occupation _____ **Family** _____

Do you smoke? _____ If so, what and how many? _____

Do you drink? _____ If so, what and how much? _____

Do you use recreational drugs? _____ If so, what and how much? _____

Describe a typical day's eating and drinking: Breakfast _____

Lunch _____

Tea (Dinner) _____

What kinds of things do you eat/drink between meals? _____

What exercise do you take? _____

How long per week? _____

What other relaxation do you have? _____

How often and how long _____

What time do you normally go to bed? _____ How many hours do you sleep? _____ Quality of sleep? _____

Height _____ **Weight** _____ **Weight five years ago** _____

Medical History

Was there anything abnormal about your birth? (i.e. premature, method of delivery, etc.) _____

Did you have normal childhood vaccinations? _____ List and if possible date any since _____

What was your health like when you were younger? _____

List surgical operations, serious illnesses/injuries/accidents with approximate dates _____

List any medication (drugs) taken over a long period _____

List any emotional traumas that you remember with approximate dates _____

Conditions, complaints, problems: In the following, please cross out those items that do not apply to you. If they do apply, please indicate the degree of severity, in either or both columns by putting:
'1' for Mild '2' for Moderate '3' for Severe

I have had	am having		I have had	am having	
		poor sleep			regular colds
		vertigo			respiratory infections
		hearing problems/tinnitus			constipation
		dyslexia			loose bowels
		fainting			high blood pressure
		epilepsy			low blood pressure
		nervous twitching			poor circulation
		headaches			cold hands and feet
		migraines			anaemia
		sight problems			chronic tiredness/lethargy
		anxiety attacks			thrush
		depression			menstrual problems
		physical abuse			prostate gland
		emotional abuse			urinary problems
		sexual abuse			sexual dysfunction
		chest pains			liver/gall bladder problems
		neck/shoulder/arm pain			kidney problems
		low back pain/sciatica			asthma
		osteoporosis			hay fever
		arthritis			skin allergies/rashes
		leg/knee pain			other allergies (specify)
		painful feet			food cravings (specify)
		other pain (specify)			

Please list in order of importance the problems that you would most like help with:

Please read and sign the following:

I understand that kinesiologists do not give medical diagnosis or treatment, but do correct imbalances that are revealed during a session. I give my consent to have kinesiology balance. I give my consent to be touched in an appropriate manner for a kinesiology balance.

I further appreciate that it is my responsibility to consult my GP about any pain, problem or disease that I am aware of, or become alerted to the possibility of, as a result of a balance.

I agree to give at least 24 hours notice of cancellation and if not will pay the full fee.

Signed Date