Record Caron Stace

Client D.O.B: 15/03/1978
Created By: Auto
Business: Soma Holistic Health
Created On: 26/10/2023 7:41 am
Activity Date: 26/10/2023 7:41 am

Personal Details

The questionnaire requires a lot of very detailed information. This assists us to identify correlations between your symptoms so we can find the underlying cause/s of your presentations. It can look a little overwhelming but we recommend taking some time out with a cup of tea or coffee and working through the form. There is no pressure to disclose anything which makes you feel uncomfortable.

First Name
Caron

Last Name
Stace

Address
72 Timbury st

City
Mango Hill

State
qld

Postcode
4509

Email
caronstace@gmail.com

Mobile Phone

0481503839

Date of Birth
15/03/1978

Occupation
Web Designer / Marketer

What is the Main Reason/s for your Visit
Shoulders always tense
Please list any Surgeries you have had (including year)
Laparoscopy 2017
Cesarean Section 2018
abdominal hernia repair 2019
Cesarean Section 2022
Please list any Medications you take regularly (if none, please write Nil)
Melatonin
Please list any Supplements you take regularly (if none, please write Nil)
multivitimin - Garden of life women vitamin code
Please list any major childhood illnesses, health conditions or accidents (if none, please write Nil)
Whiplash - 6 years old ish
Please list any allergies you have (including food, medications or essential oils)
none
Please list if there is a family history of any medical or genetic health conditions (ie. Cancer, High Blood Pressure, High Cholesterol, Parkinson's Disease, Alzheimer's Disease etc)
High Blood Pressure, Blood cancer
Do You Have a Pacemaker?
No

Are You Currently Pregnant?
No

Have you experienced Kinesiology before?
No

How Did You Hear About Soma Holistic Health
Google

Emergency Contact Details
We require these details just in case you suffered a medical episode whilst under our care. The details of your Kinesiology session would not be disclosed.
Name of Person:
Thomas Railly

Relationship
Husband

Contact Number
0466 803 632

General Medical History

Please select any of the below conditions / symptoms that you have experienced in the past or are experiencing now (can select multiple answers)
Diabetes, Hayfever, Headaches /Migraines, Insomnia /Sleeping Issues, Mental Health Concerns (further questions are on the following pages), Reproductive Symptoms or Dysregulation (further questions are on the following pages), Stress (chronic), Tiredness / Fatigue

If you selected any of the responses above, please provide some further information ie. Year diagnosed, test results, diagnosis, treatment
Migraines as a teenager - after chiropractor treatment they are just headaches.
Gestational Diabetes with second pregnancy.

Infertility - both children IVF

Please list any other conditions or concerns not listed above

Mental Health & Emotional Issues

Please select any of the below conditions / symptoms that you have experienced in the past or are experiencing now (can select multiple answers). If you have don't experience any mental health symptoms, please move onto the next section

Anxiety (generalised or social), Brain Fog, Mood Swings, Panic Attacks

If you selected any of the responses above, please provide some further information ie. Year diagnosed, test results, diagnosis, treatment

Anxiety after first pregnancy .
Panic attacks while living in London particularly 2011 when work colleague passed away. 2018 when pregnant with first daughter and traveling on train.
Mood swings seem to be pre-menstrual.

Please list any other mental health conditions or concerns not listed above

Claustrophobia - developed living in London, flairs up while driving now.

Please select whether you are under the care of one or more of the following mental health practitioners

Counsellor

Digestive Issues

Please select any of the below conditions / symptoms that you have experienced in the past or are experiencing now (can select multiple answers). If you have don't experience any digestive symptoms, please move onto the next section

Bloating, Haemorrhoids, Irritable Bowel Syndrome (IBS), Nausea or Vomiting, Weight Gain / Loss (unexplained)

If you selected any of the responses above, please provide some further information ie. Year diagnosed, test results, diagnosis, treatment

twenty years of IBS symptoms, have had many tests and last year got a dianosis of Helicobacter pylori which was treated but still get bloating sometimes related to stress or sugary foods.

Please list any other digestive conditions or concerns not listed above

Reproductive Issues (Females Only)

Please select any of the below conditions / symptoms that you have experienced in the past or are experiencing now (can select multiple answers). If you have don't experience any reproductive symptoms, please move onto the next section

Endometriosis, Fertility Issues, Miscarriage, PMS

If you selected any of the responses above, please provide some further information ie. Year diagnosed, test results, diagnosis, treatment

potential - Adenomyosis, Unable to get pregnant, two miscarriages.

Please list any other reproductive conditions or concerns not listed above

Structural Issues

If you selected Structural Issues in the first section, please complete this page. Otherwise, scroll down to the next section.

Back Pain (please also mark on diagram below)

Yes

If you answered yes, what would you rate your back pain out of 10 (with 1 being none and 10 being excruciating)

7

Neck Pain (please also mark on diagram below)

Yes

If you answered yes, what would you rate your neck pain out of 10 (with 1 being none and 10 being excruciating)
8

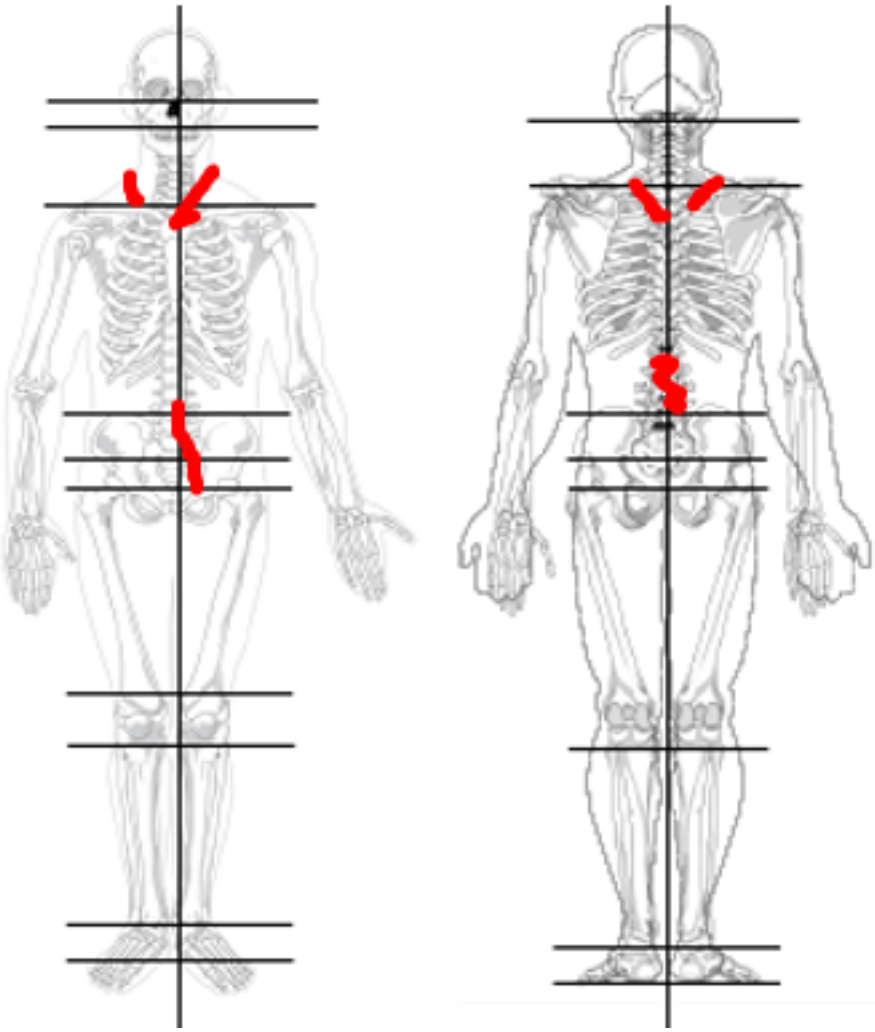
Hip Pain (please also mark on diagram below)
No

If you answered yes, what would you rate your hip pain out of 10 (with 1 being none and 10 being excruciating)

Shoulder Pain (please also mark on diagram below)
Yes

If you answered yes, what would you rate your shoulder pain out of 10 (with 1 being none and 10 being excruciating)
6

Please mark any areas that cause you pain or discomfort. You can colour the affected area or draw an arrow to the injury. You can also add text by selecting the text button and double clicking near the affected area.



Please list any events that resulted in major physical injury ie. car accidents, major falls etc.
zip wire accident aged 6 - potentially untreated whiplash
Please list any other structural conditions or concerns not listed above

Viruses

Please select any of the below conditions / symptoms that you have experienced in the past or are experiencing now (can select multiple answers). If you have don't experience any mental health symptoms, please move onto the next section
Chicken Pox / Shingles (HHV3), Coronavirus, Glandular Fever (mononucleosis), Measles, Mumps

If you selected any of the responses above, please provide some further information ie. Year

diagnosed, test results, diagnosis, treatment
unsure as a small child
Coronavirus - last Christmas and feb 2022 - while pregnant
Glandular fever aged 14
Please list any other viral conditions or concerns not listed above

Diet and Nutrition

Please select any of the answers that reflects your current daily food routine (can select multiple answers)
Meat and 3 Vegetables, Low-carb

Do you crave sugar or sweets?
No

Do you crave salty carbs?
No

Do you smoke or vape?
No

How many standard alcoholic drinks do you consume weekly on average?
1 - 2

How much water do you dink daily on average?
1 liter

Medical Reports and Tests

Please upload any relevant Medical Reports or Tests that will help us to understand your current health condition/s.

Client Consent

I give my consent for Kinesiology treatment, and understand my session is confidential. I understand that I may withdraw this consent either verbally or written at any time.
Yes

Declaration
I declare the information provided in the Client Intake Form is true and correct. To the best of my knowledge, I have disclosed all information regarding my past and present state of health. I understand it is my responsibility to inform my Kinesiologist of any changes to medication, major illnesses, or health conditions in subsequent visits. (Please refer to the Informed Consent form for detailed information relating to consent).
Name
Caron Stace

Signature