Record Kate Guy

Client D.O.B:
Created By: Auto
Business: Soma Holistic Health
Created On: 27/09/2023 10:55 am
Activity Date: 27/09/2023 10:55 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
Katrina (Kate)

Last Name
Guy

Address
10 Thomson Close

City
North Lakes, Brisbane

State
Qld

Postcode
4509

Email
Kagecreative@gmail.com

Mobile Phone

0418 883 856

Date of Birth
17/10/1978

Occupation
Graphic Designer / Manager

What is the Main Reason/s for your Visit
Diagnosed in June with 11cm GIST attached to small intestine. Tumor removed along with 30cm of small bowel.

Please list any Surgeries you have had (including year)
Abdominal surgery for removal of GIST and bowel resection June 13 2023, ovarian dermoid 2007

Please list any Medications you take regularly (if none, please write Nil)
Lexapro 20mg and Imatineb 400mg

Please list any Supplements you take regularly (if none, please write Nil)
Probiotics and Metagenics Immunogenics

Please list any major childhood illnesses, health conditions or accidents (if none, please write Nil)
Nil

Please list any allergies you have (including food, medications or essential oils)
Penicillin and lavendar

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)

Do You Have a Pacemaker?
No

Are You Currently Pregnant?
No

Have you experienced Kinesiology before?
Yes

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:
Travis Guy

Relationship
Husband

Contact Number
0415 456 603

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)
Adrenal Fatigue, Cancer, Insomnia /Sleeping Issues, Mental Health Concerns (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
Anxiety moat of life, have not slept a full night in 14years, tired generally but even more so on cancer treatment

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), Concentration (difficult to maintain focus), Depression, Mental or Emotional Exhaustion, Excessive Worry, Fear of the Future, Memory issues, Motivation (lack of), Nightmares / Night Terrors, Overwhelm (regular), Panic Attacks, Self-worth (low)

If you selected any of the responses above, please provide some further information ie. Year diagnosed, test results, diagnosis, treatment
Please list any other mental health conditions or concerns not listed above
Please select whether you are under the care of one or more of the following mental health practitioners
Counsellor, Psychologist

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
Abdominal Pain, Gastritis, Nausea or Vomiting

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

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

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

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)
/10

Hip Pain (please also mark on diagram below)

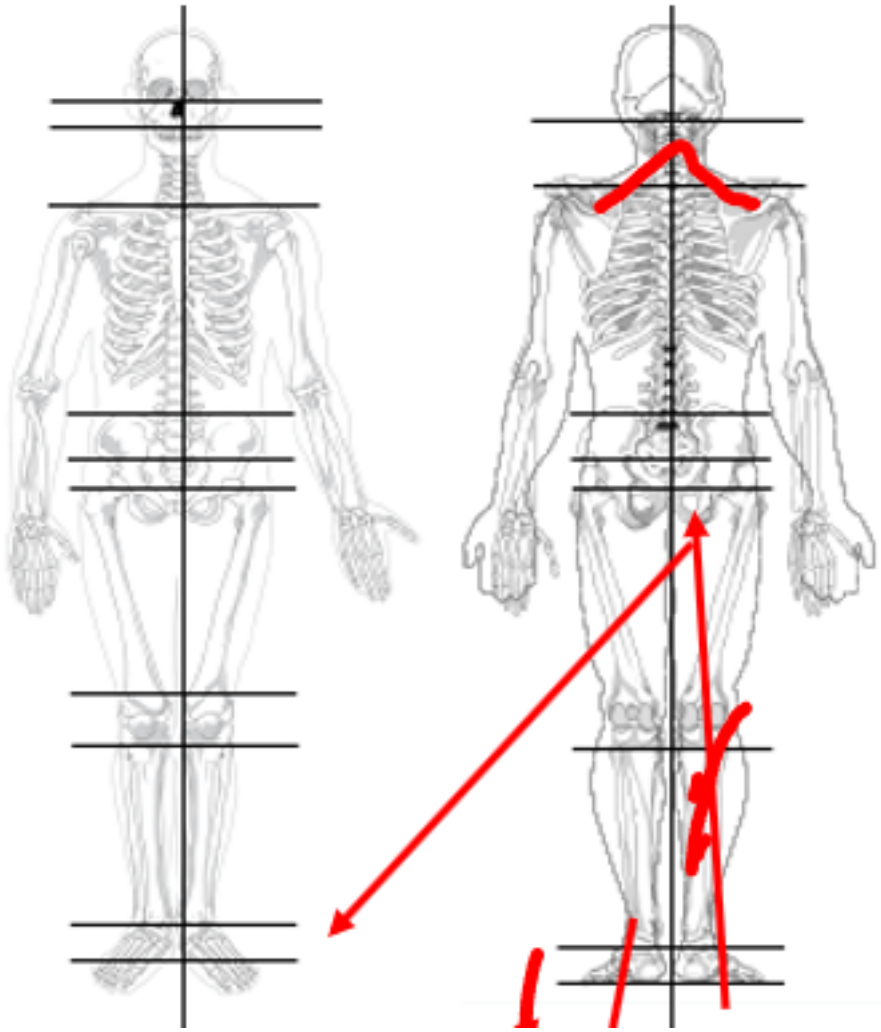
If you answered yes, what would you rate your hip pain out of 10 (with 1 being none and 10 being excruciating)
/10

Shoulder Pain (please also mark on diagram below)

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

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.
Neck area only, had a few issues with the pen tool
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
Coronavirus, Glandular Fever (mononucleosis)

If you selected any of the responses above, please provide some further information ie. Year diagnosed, test results, diagnosis, treatment
Covid 2022, glandular fever 2012
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, Sugar-free, Low-fat

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?
0

How much water do you dink daily on average?
0

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
Katrina Guy

Signature