New Client Intake Form

SOMA holistic health

5/25 Discovery Drive, North Lakes Q 4509
Email: info@somaholistichealth.com.au

Name:			Email: info@	somaholistichealt Mb: 0427	
Date of Birth:					.007.12
Contact Number					
Email Address					
Address:					
Would you like to receive our monthly newsletter?	Yes	No			
I found out about Kinesiology through Friend	Google	Facebook	Referral	Other	
Reason for visit					
Please list any					
surgeries (including dates)					
Current					
medications					
Current					
supplements					
Your safety and comfort are our top priority. Please advi	ise us if there	are any cultural s	ensitivities the	at vou would lil	ce us to
be aware of.	ise us il tilele	are arry cultural s		it you would lif	ic us ic
Do you have any internal devices such as a pacemaker?	? No	Yes			
Are you pregnant?	No	Yes			

Test results (blood tests, pathology, histology, X-Rays, MRIs) provide really great information so if you have any test results please bring them to your appointment

MEDICAL HISTORY

The medical history provides valuable clues to the underlying cause/s of the symptoms you may be experiencing. Please tick any relevant medical conditions, viruses, vaccinations, mental health and emotional concerns.

PHYSIOLOGICAL

Adrenal fatigue	Diabetes	HIV/AIDS	Peripheral neuralgia
Allergies	Digestive condition	Hormone imbalance	PMS
Arthritis	Dizziness/ vertigo	IBS	POTS
Asthma	Dysmenorrhoea	Insomnia/sleeping issues	Reproductive issues
Auto-immune	Eating disorder	Joint pain/swelling/stiff	Respiratory issues
Back pain	Eczema/dermatitis	Kidney conditions	Scoliosis
Blood Pressure (high/low)	Endocrine condition	Lime Disease	Sinus pain/congestion
Broken bones	Endometriosis	Lupus	Skin conditions
Cancer	Epilepsy/seizures	Lymphoma	Spinal injury
Chronic Fatigue Syndrome	Excessive sweating	Multiple sclerosis	Sprains/strains
Chronic Pain	Fibromyalgia	Muscle tension/cramps	Stress
Cold/Flu/Fever	GERD	Musculoskeletal pain/injury	Thyroid
Coeliac disease	Grave's disease	Neck pain/tightness	Tinnitus
Constipation/Diarrhea	Hay Fever	Nervous system issue	Tiredness/fatigue

VIRUSES

Numbness/tingling

Osteoporosis

Varicose veins

Visual impairment

Headaches/migraines

Heart condition

Crohn's disease

Dental condition

Chicken Pox/Shingles (HHV3)	Hepatitis C	Mumps
Adenovirus	Human Herpes Virus 1 (cold sores)	Norovirus
Avian influenza (bird flu)	Human Herpes Virus 2 (genital herpes)	Polio
Coronavirus	Epstein Barr (HHV4)	Ross River Fever
Dengue Fever	Cytomegalovirus (HHV5)	Spike Protein (SARS-CoV-2)
Enterovirus	Human papillomavirus (HPV)	Swine Flu
Hepatitis A	Huma parainfluenza virus (croup)	Zika virus
Hepatitis B	Measles	

MENTAL HEALTH

ADHD	Obsessive compulsive disorder (OCD)	Motivation (lack of)
Agoraphobia	Paranoia	Concentration
Anxiety (general) incl. panic attacks	Phobias	Brain fog
Bipolar	Post-traumatic stress disorder (PTSD)	Memory issues
Claustrophobia	Psychosis	Addiction/substance abuse
Depression	Schizophrenia	Mood swings
Dissociation/dissociative disorders	Sensitivity to light or sound	Negative thoughts
Eating disorder	Social phobias/anxiety	Suicidality

EMOTIONAL HEALTH

Aggression Grief/loss Relationship issues

Alienation Guilt Resentment
Anger/Rage Hopeless Sadness
Avoidance of feelings Indifference Self-doubt

Communication issues Judgement Self-esteem issues

Despair Loneliness Self-image

Excessive worry Nervousness Self-worth issues

Exhausted (emotionally) Overwhelm Shame

Fear Panic Stubbornness

Fear of failure Rapid weight gain (more than 5 kg) Suppression of feelings

Fear of Success Rapid weight loss (more than 5kg) Terror

VACCINATIONS

Chicken pox Flu shot Pneumococcal

Coronavirus (AstraZeneca)Hepatitis BPolioCoronavirus (Moderna)Human papillomavirus (HPV)RotavirusCoronavirus (Novavax)Measles & MumpsRubellaCoronavirus (Pfizer)MeningococcalShinglesDiphtheriaPertussis (whooping cough)Tetanus

FAMILY HISTORY (Immediate Family)

Cancer	Self	Father	Mother	Sibling
Tuberculosis	Self	Father	Mother	Sibling
Diabetes	Self	Father	Mother	Sibling
Heart conditions (incl. blood pressure)	Self	Father	Mother	Sibling
Parkinson's disease	Self	Father	Mother	Sibling
High Cholesterol	Self	Father	Mother	Sibling

What other forms of therapy do you use to resolve health problems?

Doctor Acupuncture Massage
Specialist Naturopathy Reflexology

Chiropractic Osteopathy Psychologist/Psychiatrist/Counsellor

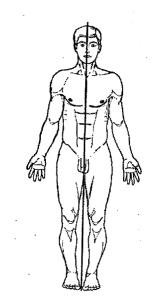
Physiotherapy Herbalist Other

Please tick those that best describe your normal daily food routine

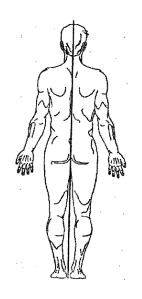
Meat & 3 Veg	Keto	Low-Carb	Low-fat	Crave sugar/sweets
Vegetarian	Gluten Free	Mediterranean	Diabetic diet	Crave salty/carbs
Vegan	Dairy Free	FODMAP	Atkin's diet	Regular take out
Paleo	Sugar Free	Inulin Free	Specialised diet	Other

STRUCTURAL CONCERNS

If you are currently experiencing any structural issues or misalignments, please complete the chart below







Body Area	Description of Misalignment		

F	Any other information you wish to disclose:					

CLIENT DECLARATION

I declare that the above information is true and correct. I understand that it is my responsibility to inform my Kinesiologist of any changes to medication and major illnesses or conditions in subsequent visits. I understand and accept that Kinesiology is a complimentary therapy and is in no way diagnostic or curative. I understand and accept that the results of the treatment are not guaranteed in any way.

I understand and accept that any personal information I provide in the Confidential Client Information Form and notes made by the therapist in my Session Records, will remain the property of the clinic and will be securely stored and kept in strict confidence. I am aware that I may request in writing, to view or access copies of the records detailing my personal information, which is held by the clinic.

I understand and accept that my written permission is required to provide consent to any records that detail my personal information, being disclosed to any other party. I am also aware that I am able to view the Privacy Policy of the clinic at any time.

Name:			
Date:			