Client Record Form

First Name Mel Surname Rhodes DOB 8/7/75

Address 37 The Promenade Suburb Springfield Lakes Postcode 4300

Mobile 0412239948 Email mel-rhodes@ymail.com

Occupation Defence - Air Force Gender Male ☐ Female ☑ Intersex ☐

I found out about Kinesiology through: Friend ☐ Google ☐ Social Media ☐ Other ☒ Referral ☒

Reason for visit	Chronic fatigue
Please list any cultural/religious sensitivities	nil.
Please list any surgeries including dates	Sinus - 2018
Current medications	nil
Current supplements	Iron magnesium Zinc adrenal support Vit C Vit D Vit B

Do you have any medical tests/reports with you? ☒ No ☒ Yes Blood tests

Do you have any internal devices such as a pacemaker? ☒ No ☐ Yes _____

Are you pregnant? ☒ No ☐ Yes _____

Medical Conditions

Please indicate any injuries, illnesses, medical conditions and experiences:

- ☐ Musculoskeletal pain/injury
- ☐ Muscle tension/cramps
- ☐ Sprains/strains
- ☐ Arthritis
- ☐ Headaches/Migraine
- ☒ Tiredness/fatigue
- ☐ Heart condition
- ☐ Varicose veins
- ☐ Respiratory condition
- ☐ Immune system condition
- ☐ Cancer
- ☐ Tinnitus
- ☐ Nervous system condition
- ☐ Reproductive condition
- ☐ Epilepsy/ seizures
- ☐ Hormone Imbalance
- ☐ PMS syndrome
- ☐ Depression
- ☐ Digestive condition
- ☐ Chronic pain
- ☐ Numbness/tingling
- ☐ Broken bones
- ☐ Painful joints
- ☐ Dizziness/ vertigo
- ☐ Asthma
- ☐ High/Low blood pressure
- ☐ Diabetes
- ☐ HIV
- ☐ Neck or spinal injury
- ☐ Endocrine condition
- ☐ Insomnia
- ☐ Constipation/Diarrhea
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Skin conditions
- ☐ Cold/flu/fever
- ☒ Dental condition
- ☐ Visual impairment
- ☒ Allergies
- ☐ Addictions
- ☐ Back Pain
- ☐ Eating Disorder
- ☐ Desired healthy weight
- ☐ Self-image
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Concentration/ focus
- ☐ Depressive thoughts
- ☐ Grief/ loss
- ☐ Guilt / shame
- ☐ Loneliness / isolation
- ☐ Anger / aggression
- ☐ Mood swings
- ☐ Relationship challenges
- ☐ Self-esteem/ self-worth issues
- ☐ Unhappiness/happiness
- ☐ Stress
- ☒ Motivation lacking
- ☐ Overcoming painful memories
- ☐ Other _____

Do you have a family or personal history of:

☐ Diabetes ☐ Thyroid ☐ Blood Pressure ☐ High Cholesterol ☒ Cancer ☐ Heart Conditions ☐ Parkinson's Disease

☒ Arthritis ☐ Coeliac ☐ Allergies ☐ Auto-immune

Details (family member): Mums side of family - history breast cancer depression - Dad + sister

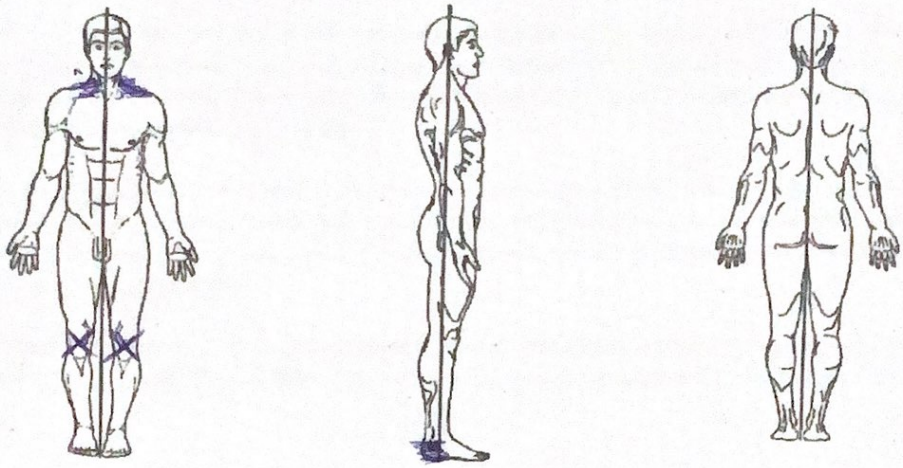
Vaccinations

Please list any vaccinations that you have had in the past 15 years

COVID 1st + 2nd vac

Hep A

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



Body Area	Description of Misalignment
Knees	weak/slightly painful
shoulders/neck	tension
heels	plantar faciitus.

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

- [x] Doctor
- [x] Specialist
- [ ] Chiropractic
- [ ] Physiotherapy
- [ ] Acupuncture
- [x] Naturopathy
- [ ] Osteopathy
- [ ] Herbalist
- [x] Massage
- [ ] Reflexology
- [x] Psychologist/Psychiatrist/Counsellor
- [ ] Other _____

Please tick those that best describe your Normal daily food routine

- [ ] Meat & 3 Veg
- [ ] Vegetarian
- [ ] Vegan
- [ ] Paleo

combination

- [ ] Keto
- [x] Gluten Free
- [x] Dairy Free
- [x] Sugar Free
- [x] Crave sugar/sweets — crave dark/nut choc > 75% cocoa ~~only~~ is only added sugar to diet
- [ ] Crave salty/carbs
- [ ] Regular take-out
- [ ] Other _____

Other information:

+ follow a Lectin free diet.
  2-3 L water daily
  eat 3-4 hrs or feel dizzy, light headed
  have smaller meal portions

+ recently (Feb 22) came off pill after a lengthy time. Took 6 mths plus & now having light period but not what I would consider normal

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.

Signed: _____ Date: 6 Dec 22