**Confidential Client Questionnaire** 1 of 3

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| To give you the maximum benefit in your session please fill in your form with as much details as you feel required and return it a minimum of 48hrs before your session commences at: brightsidebioenergetics@gmail.com | | Name: |
| Address: |
| How did you find out about me: | | Contact telephone numbers: |
| Occupation: | | Contact mobile no: |
| Date of birth: | | e-mail: |
| GP’s name and address:  GP’s contact number: | | |
| **Family situation**  (please circle) | Single Living alone Living with parents Living with partner  Married Separated Widowed Other | |
| Names of your  Parents and siblings:  Spouse/ partner’s first name:  Children’s names & ages: | | |

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| **Medical history** | ***Past surgery, serious illness, accidents/injuries - with approximate dates:***  **Do you have a Pace Maker: Yes/No Have you ever had a Mammogram: Yes/No. N/A**  **Have you ever sprained your ankle: Yes/No Right - Left - Both** |
| ***Significant childhood illnesses:*** | |
| ***Stress/ complications, etc. about your birth*:** | |

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| ***The areas you wish to address in your sessions:*** |

Confidential Client Questionnaire 2 of 3

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| ***List any emotional traumas/ episodes, with approximate dates, as far back as you like.***  ***(e.g. bereavements, divorce, parents split-up, loss of a job/ home, etc.)***  ***Describe current relationship challenges: work, family, friends, etc.*** |
| Are you happy with your diet and weight. Yes/No  If not please clarify your concern:   |  |  | | --- | --- | | **Diet** | Describe a typical day’s eating & drinking: | | Breakfast: | | | Lunch: | | | Evening meal: | | | Between meals: | | | List regular exercise and methods of relaxation: | |   Dental history: (dates and numbers of, extractions, crowns, filling materials, amalgams replaced, fluoride treatment, braces.)  **Have you ever had root canal surgery: Yes/No**   |  |  | | --- | --- | | **Medication** | List current medication and what they are for: | | List long term medication of the past, you are no longer taking: | | | Have you reacted to any medication: Yes/No  To what: How:  When: | | | Do you smoke: Yes/No If so, what and how much per day: | | | Do you drink alcohol: Yes/No If so, what & how often: | | | Use of recreational drugs: At present? Yes/No If so what & how often:  In the past? Yes/No If so what: | | |

Confidential Client Questionnaire. 3 of 3

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|  | **I am having:**  (tick + any comment such as how long for) | **I have had, but not now:**  (tick + any comment such as when) |
| Anxiety |  |  |
| Breathing difficulty |  |  |
| Chest pains |  |  |
| Constipation |  |  |
| Depression |  |  |
| Dizziness |  |  |
| Fainting |  |  |
| Fits |  |  |
| Food cravings |  |  |
| Headaches |  |  |
| Hearing problems |  |  |
| Known allergic reactions |  |  |
| Lethargy |  |  |
| Loose bowels |  |  |
| Low sex drive |  |  |
| Other sexual problems |  |  |
| Menopausal problems |  |  |
| Migraines |  |  |
| Nervous twitches/ tremors |  |  |
| Pain: back |  |  |
| Pain: joint |  |  |
| Pain: neck/ shoulder |  |  |
| Pain: other |  |  |
| PMT / Menstrual problems |  |  |
| Poor circulation |  |  |
| Poor sleep |  |  |
| Repeated infections |  |  |
| Runny eyes |  |  |
| Runny nose |  |  |
| Skin rash |  |  |
| Sneezing |  |  |
| Sore throat |  |  |
| Spotty skin |  |  |
| Stuffy sinuses |  |  |
| Vision problems |  |  |
| Other problems |  |  |

**Please read and sign the following statement:**

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| I understand that kinesiologists do not give **medical** diagnoses or treatment, and that it is my responsibility to consult my GP about any medical problem that I am aware of or become alerted to in the course of a HK session.  Signed: Date: |