**Confidential Client Questionnaire** 1 of 3

|  |  |
| --- | --- |
| 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 partnerMarried Separated Widowed Other |
| Names of yourParents and siblings:Spouse/ partner’s first name:Children’s names & ages: |

|  |  |
| --- | --- |
| **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*:** |

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

Confidential Client Questionnaire 2 of 3

|  |
| --- |
| ***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/NoIf 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

|  |  |  |
| --- | --- | --- |
|  | **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:**

|  |
| --- |
| 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: |