CLIENT HISTORY FORM

This is a confidential record, all personal information is kept in strict confidence and not shared with any other party without your consent.

Name: _____ Surname: _____

Address: _____

City: _____ Postal Code: _____

Contact Number: _____ Email: _____

Birthdate: _____ Age: _____

Marital Status: _____ Children: _____

Occupation: _____ Referred By: _____

Are you seeing any other health professional and if so, what for:

_____

_____

_____

_____

Current drugs or medication (prescription or recreational):

_____

_____

_____

_____

Current supplements:

_____

_____

_____

_____

Past accidents/operations (include date and age):

☐ Back injury	☐ Broken bones	☐ Brain injury
☐ Head injury	☐ Internal organ injury	☐ Muscular injury
☐ Neck injury	☐ Skeletal injury	☐ Torn ligaments/tendons
☐ Other: _____	☐ Other: _____	☐ Other: _____
☐ Back surgery	☐ Blood transfusion	☐ Brain surgery
☐ Head Surgery	☐ Internal organ surgery	☐ Ligament/tendon repair
☐ Mastectomy	☐ Muscular surgery	☐ Neck surgery
☐ Organ removal	☐ Skeletal surgery	☐ Reconstructive surgery
☐ Other: _____	☐ Other: _____	☐ Other: _____

_____

_____

_____

Please check if you have experienced any of the below conditions:

☐ ADD	☐ ADHD	☐ Allergy/ies
☐ Anemia	☐ Anxiety	☐ Asthma
☐ Autism	☐ Back pain	☐ Bronchitis
☐ Blood Pressure – High	☐ Blood Pressure – Low	☐ Bleeding
☐ Candida	☐ Chest pain	☐ Cholesterol
☐ Constipation	☐ Croup	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Dizziness
☐ Eczema	☐ Epilepsy	☐ Fatigue
☐ Food Intolerance/s	☐ Gingivitis	☐ Hay fever
☐ Headache/s	☐ Heart burn	☐ Heart complaints
☐ Hepatitis A, B or C	☐ Hernia	☐ HIV/AIDS
☐ Hot Flushes	☐ Insomnia	☐ Itching / rash
☐ Jaundice	☐ Low blood sugar	☐ Low grade fever
☐ Malignant Melanoma	☐ Menstrual cramps	☐ Migraine/s
☐ Muscle Cramps	☐ Nausea	☐ Neck pain
☐ Numbness or tingling	☐ Osteoporosis	☐ Pain / inflammation
☐ Palpitations	☐ Panic Attacks	☐ Pregnancy
☐ Pneumonia	☐ Regular colds or flu	☐ Rheumatoid Arthritis
☐ Rheumatic Fever	☐ Ringing in ears	☐ Shortness of breath
☐ Sleeping difficulty	☐ Swollen glands	☐ Tonsillitis
☐ Urinary/genital	☐ Vomiting	☐ Weight – gain
☐ Weight – loss	☐ Childhood Vaccs?	Other?

_____

_____

Do you smoke?	☐ No ☐ Yes	Number per day or week? _____
Do you drink alcohol?	☐ No ☐ Yes	Number per day or week? _____
Do you exercise?	☐ No ☐ Yes	How many times a week? _____
Do you drink water?	☐ No ☐ Yes	How many glasses a day? _____

Please give brief details of any familial health problems:

Relation Current or past health conditions

_____

_____

_____

_____

Please list any details you know about your birth and/or the birth of your children (i.e. natural childbirth, caesarean, premature, forceps, induced, incubation etc.):

_____

_____

_____

_____

Please describe your family dynamics (i.e. sibling order, relationship between parents, siblings, children, etc.):

_____

_____

_____

_____

Emotional trauma (include date and age):

_____

_____

_____

_____

_____

Important events that lead to deterioration in health:

_____

_____

_____

_____

Physical Activity:

Type:

_____

_____

Times a Week: _____

Duration: _____

Chronic conditions already diagnosed & any Prescription medication currently taken for the condition/s:

(year diagnosed and condition)

_____

_____

_____

_____

_____

_____

_____

Prescription Medicine/s taken & Dosage:

_____

_____

_____

_____

_____

_____

_____

Sources of Water:

Main Source: Tap_____ / Bottle_____ Plastic_____/ Glass_____

Alternative source / Filter_____ Filter brand _____

Meals:

I eat breakfast ____ times a week, usually at _____ am. My typical breakfast is:

_____

_____

_____

_____

I usually eat lunch ____ times a week, usually at _____ pm. Typical lunch is:

_____

_____

_____

_____

I eat supper ____ times per week, usually at _____ pm. Typical supper is:

_____

_____

_____

_____

_____

Bowel Movement:

Current frequency of bowel movement_____ per day/_____ per week
Stools: Normal_____Hard_____Loose_____Sticky_____
Colour of stool: Light Brown_____/Dark Brown_____/Pale_____/Orange_____
Black _____
Stool Float_____ Sink_____
Stool smells like rotten eggs (sulfur)_____ or Ammonia (window cleaner)_____
or like metal_____

Current complaints in order of priority:

_____

_____

_____

_____

_____

_____

_____

Blood tests:

Do you have any blood test results done through Pathcare Labs in the past 3 years? If yes download the Pathcare patient app on your phone and sign up to create an account. This will give you access to all the results of blood tests done on you.

Your blood is a delivery system for oxygen, immune products and nutrients, all the good stuff, but it also carries less desirable things that have to be filtered by the liver like toxins, bacteria, viruses, parasites and fungal metabolites. To have a functional blood analysis done, please email me the results of the last 3 blood tests ahead of your session.

Stress:

Are you currently experiencing high stress in your life? _____

Do you struggle to manage your mood and health during stressful times? _____

Do you consider yourself as a highly-strung person? _____

Sleep:

What time do you go to bed? _____

How many hours of sleep do you get per night? _____

Do you wake up feeling tired? _____

Do you wake up with a headache? _____

Do you struggle to:

1. Fall asleep? _____
2. Fall asleep, but wake up a few hours later and battle to go back to sleep? _____
3. Sleep 10 hours per night? _____

Have you ever measured how much DEEP sleep you get each night? _____

Do you dream frequently? _____

Do you often have nightmares? _____

Do you have a TV in your bedroom? _____

Do you charge your cellphone/laptop in the bedroom? _____

Do you sleep with the cellphone under the pillow o near your head? _____

Do you have or have you ever had silver (amalgam) fillings in your teeth?

_____

_____

_____

What do you want to have happen as an outcome of this session and future sessions?

_____

_____

_____

_____

_____

_____

_____

Reason why you are here today:

_____

_____

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_____

CONSENT FORM

I, ……..
(name of client or, in the case of a minor, parent/guardian) hereby acknowledge that, before consulting with me, **Lynn Angel**, made it clear to me that she works in accordance with the terms and conditions of the Code of Ethics and Member's Codeof the Association of Specialised Kinesiologists, South Africa, as displayed in the practice rooms.

Furthermore, I acknowledge that she:

- Does not diagnose or treat a named disease,
- Does not have the authority to take me off any prescribed medication,
- May suggest that specific nutrition or essences may be advantageous for me to take – however the decision on whether to follow her advice is entirely my own.

I have been advised that neither the Association of Specialised Kinesiologists, nor it's individual members nor, **Lynn Angel**, will be legally liable or responsible for any risk of illness, injury, or aggravation of any medical condition whatsoever that may arise out of the consultation with me, and arising out of my failure to consult with and obtain approval from a registered medical doctor prior to commencing sessions with **Lynn Angel**. I hereby consent to such consultation and indemnify the Association, its members and **Lynn Angel** against any and all claims by myself, my successors and assign in this regard.

Please note that appointments cancelled 24 hours in advance will not be charged for.

_____ _____

Signature of client or parent/guardian Date