LI LIN CHEAH
KINESIOLOGY

Confidential Client Questionnaire

YOUR PERSONAL DETAILS		
Given Name:		Family Name:
Address:		Email:
		Phone (Work):
		Phone: (Home):
State:	Postcode:	Phone: (Mobile):
Date of Birth: / /	Age:	Gender: Male / Female
Main Occupation:		Marital Status: Single / Married / De Facto / Other
Number of Siblings and their Name, Age, Gender		Number of Children and their Name, Age, Gender
Spouse / Partner and their Name and Age		Current Medical Doctor / Health Professional and their Name and Contact Number
Health Fund Name:		How did you know about Li Lin Cheah Kinesiology?

REASON(S) WHY YOU ARE HERE

YOUR HEALTH BACKGROUND

CIRCLE any conditions below that you may have experienced in the **past 6 to 12 months** and/or mark with an X **if more than 12 months**. Please indicate severity level i.e. 0: no pain and 10: most painful

□ Lower back pain	□ Upper/mid back pain	□ Dizziness	□ Headaches
□ Asthma	□ Ringing in ears	□ Regular colds/flu	□ High blood pressure
□ High blood pressure	□ Low blood pressure	□ Tired / fatigue	□ Chest Pain
□ Nervous/anxiety	□ Neck pain	□ Tension in body	□ Numbness/tingling
□ Depression	□ Difficulty sleeping	□ Muscle cramps/sprains	□ Heart condition
□ Allergies / sensitivities	□ Digestive problems	□ Epilepsy	□ Fainting spells
□ Diarrhoea	□ Constipation	□ Diabetes	□ Weight problems

List and describe any other health concerns including their severity level:

What treatments have you tried prior to today?

List all surgery you have had and at what age:

List all major traumas, fractures, falls, accidents, illnesses:

If applicable, are you pregnant, indicate stage and when you are due:

YOUR LIFESTYLE BACKGROUND

How many hours do you sleep each night: Time you retire: am/pm Time you arise: am/pm

Describe the quality of your sleep:

Describe your physical exercise routine:

□ Daily □ Weekly □ Number of times a week: Other:

Do you smoke: Y/N	Number per day:	How long have you smoked:

What drugs (medical or recreational) are you currently taking (include frequency and dosage):

What supplements and/or herbs are you currently taking (include frequency and dosage):

List any known sensitivities or allergies (inhaled, contact or ingested):

YOUR LIFESTYLE BACKGROUND (Continued)			
Indicate your usual diet:			
□ Meat & 3 veg	□ Vegetarian	□ Vegan	□ High protein
□ Macro	□ Wheat free	□ Gluten free	□ Dairy Free
Daily intakes of: Water, number of cups or litres			
□ Sugar	□ Coffee	□ Tea	□ Alcohol
Additional diet information or concerns:			
Please give brief details of any health problems in your family history i.e. great grandparents, grandparents, parents, children, cousins etc in relation to current and/or past health problems:			
Additional relevant information or health concerns:			

DECLARATION

I declare that the above information is true and correct and indemnify your practice, Li Lin Cheah Kinesiology, of any liability for any false or misleading statements given.

I further understand:

1. that the treatment is of a holistic and remedial nature, that it is not of a diagnostic or curative approach and the results of the treatment are not guaranteed in any way;
2. that any data or notes taken during the sessions will remain the property of your clinic as part of case history records;
3. that a copy of any kept personal records will be made available to me within 48 hours of my written request at any such time and that my personal information, unless otherwise noted by me, may be used by your practice for notification of any future news, products or services as deemed appropriate by your practice;
4. I give permission to your practice to use information that will not identify myself and any results arising from treatments for use toward case studies and/or research; and
5. I am attending your practice on my own free will and consent and exercise my right to discuss and choose any suitable treatments available to me.

I understand that no account is rendered by your practice and my payment is at the time of the service and is made by cash or where available, EFTPOS. **In addition I understand and accept the cancellation policy of your practice is 24 hours notice with a 50% consultation fee to be paid if the appointment is cancelled inside 24 hours and if within 12 hours the full consultation fee will apply.**

Client Signature (parent or guardian if under age 16):_____

Client Name: _____

Date: _____/_____/_____