Applied Kinetic Concepts

Client History Date:_____

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

First Name:_____ Last Name: _____

Address: _____ City: _____

State: _____ Zip: _____Email: _____

Date of Birth: _____ Phone: _____

Referred By: _____Would you like to receive news via email ?

Occupation: _____Yes_____ No _____

Marital Status: _____ Children: _____

_____

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

_____
_____
_____
_____

Past Trauma/ accidents (Include date and age):

_____
_____
_____
_____

Past Surgery (Include date and age):

_____
_____
_____

Childhood or any illness (include date and age)

_____
_____

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Client History Date:_____

Current Medication: medical or recreational

_____

_____

_____

Current supplements:

_____

_____

_____

Do you have any food allergies or intolerances?

_____

_____

_____

Current problem or reason you are here today:

_____

_____

_____

_____

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

_____

_____

_____

_____

Have you experienced any of the following conditions in the last 6-12 months? Please circle if you have.

Back pain	Diabetes	Headaches
Regular colds and flu	Depression	Fatigue
Neck pain	Chest pain	Anxiety
Heart conditions	Dizziness	Weight Issues
Difficult sleeping	Digestive issues	Blood pressure issues
Hormone issues	Numbness or tingling in the body	
Pregnancy	Allergies	Ringing in the ears
Mental issues	Epilepsy	Others

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Do you smoke? Yes or No Number per day or week?_____

Do you exercise? Yes or No How many times a week?_____

Please give brief details of any family health problems:

_____
_____
_____
_____
_____
_____

Relation

_____
_____
_____

Current or past health condition

_____
_____
_____
_____
_____
_____

Notes: