HEART ♥ OF THE MATTER
amyroykinesiology@gmail.com Tel: 07512 164542

# CLIENT REGISTRATION FORM

## PERSONAL DETAILS AND CONTACT INFORMATION

*Your privacy is important. All information submitted on a client history form is confidential, only used for the purposes of achieving the most beneficial work in a session, and for contacting you in relation to your sessions. Personal information is not used for marketing or made available to any third party. This Client Registration Form will be printed and filed in a locked cabinet after which the digital copy will be deleted. Records are destroyed 7 years following a client's final session, in accordance with Balens Insurance Ltd.*

| | |
|---|---|
| FULL NAME | |
| TELEPHONE (Home/Work/Mobile) | |
| EMAIL | |
| FULL HOME ADDRESS | *POST CODE* |

## BIRTH DETAILS

*(I may use birth details to create an astrological birth chart. Please ignore PLACE & TIME OF BIRTH if not desired)*

| | | | |
|---|---|---|---|
| AGE | | DATE OF BIRTH | |
| TIME Tick if unknown | ☐ | PLACE (Country/town) | |

## PLEASE INDICATE THE METHOD OF SESSION DELIVERY PREFERRED

| | | | |
|---|---|---|---|
| ONLINE VIA : | SKYPE ☐ | FACETIME ☐ | WHATSAPP ☐ |
| IN PERSON (Home clinic) ☐ | | ABSENT ☐ | |

PLEASE PROVIDE YOUR SKYPE/FACETIME/WHATSAPP address/contact

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## CURRENT HEALTH - STATUS AND PROVIDERS

This section gives me a picture of your current health – ie conditions you are currently experiencing and treatments you are undergoing. I will always recommend working in cooperation with your GP/Specialist.

### GP INFORMATION

| | |
|---|---|
| NAME | |
| ADDRESS | |
| CONTACT TELEPHONE | |

ARE YOU CURRENTLY UNDER THE CARE OF YOUR MEDICAL DOCTOR FOR ANY MEDICAL CONDITION?

NO ☐ YES ☐

*Please provide brief details below*

ARE YOU CURRENTLY TAKING ANY MEDICATION? YES ☐ NO ☐

*Please provide details below (Name of medication, what it is for and when you started to take it)*

If possible it can be useful to bring any medication with you to your first appointment.

ARE YOU CURRENTLY PREGNANT ☐ BREASTFEEDING ☐ TRYING TO CONCEIVE? ☐

DO YOU HAVE ANY KNOWN ALLERGIES YES ☐ NO ☐

*Please provide brief details below*

ARE YOU CURRENTLY RECEIVING ALTERNATIVE/COMPLEMENTARY HEALTH OR MENTAL HEALTH CARE?

*(eg Chiropractor, Counselling, etc)* YES ☐ NO ☐

*Please provide brief details below*

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ARE YOU CURRENTLY TAKING ANY SUPPLEMENTS / HERBS / REMEDIES? YES ☐ NO ☐

*Please provide brief details below*

(if possible it is useful to bring these with you to your first appointment)

## PERSONAL RELATIONSHIPS

This section helps me to understand your family dynamics which may be relevant to our consultation

### MARITAL STATUS

SINGLE ☐ MARRIED/PARTNERSHIP ☐ DIVORCED ☐ WIDOWED ☐

### FAMILY DYNAMICS

*Please provide details of your current relationship with your family members. Please include any difficulties or issues past or present or any particularly strong bonds that may be relevant.*

PARENTS

*Please provide details (eg divorced/remarried/adoptive)*

DEPENDENTS (CHILDREN, etc)

*Please provide details of age, name, etc*

SIBLINGS

*Please provide details of age, name, relationship etc*

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## PERSONAL SIGNIFICANT EVENTS

EMOTIONAL STRESS OR TRAUMA. Please provide details below of any periods of significant emotional stress or trauma you have experienced at any time (childhood/teens/adult life). This might include divorce, bereavement, redundancy, bullying for example. Please indicate your age at the time.

ILL HEALTH OR PHYSICAL TRAUMA – Please give brief details below of any physical health conditions / mental health conditions / accidents & injuries you have experience at any time (childhood/teen/adult). Please indicate your age at the time.

OTHER EVENTS

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| WORK | |
|---|---|
| YOUR OCCUPATION | |

WORK RELATED STRESS – please briefly describe below any difficulties you may be experiencing at work.

## GOALS AND CONCERNS

This section helps me to identify and prioritise what you would like helps with and what you would like to achieve from your appointments

Please give a brief description of the issues you would like to address. *These may be symptoms or problems on any level of your being – physical, mental, emotional, spiritual or they may be personal goals that you would like help with.*

## WHAT ARE YOUR PRIORITES?

*Please list below, starting with the most important. Where appropriate, please indicate the level of pain/discomfort you experience by rating it on a scale of 1-10 (where 1= little and 10 = intense discomfort)*

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| IS THERE ANYTHING ELSE NOT YET MENTIONED THAT IS IMPORTANT OR RELEVANT TO YOUR CURRENT ISSUE/GOAL?<br>*Please give details below.* |
|---|
| |

| IMPORTANT INFORMATION AND DECLARATION | |
|---|---|
| 1. NUTRITIONAL SUPPLEMENTATION may be an important part of your recommended treatment and is charged separately | I understand and agree ☐ |
| 2. I will never recommend making any alteration to your prescribed medication without consulting the professional who issued that prescription. You are responsible for your own compliance to medication you have been prescribed. | I understand and agree ☐ |
| 3. MISSED APPOINTMENTS: please be aware that missed appointments will be charged at full price unless at least 24 hour's notice is given. | I understand and agree ☐ |
| 4. DECLARATION: I take full responsibility for my own health and wellbeing and accept the outcome of any advice or treatment I receive in this consultation. I accept them as being complementary to and not instead of qualified professional medical treatment. | I understand and agree ☐ |
| SIGNED: | DATE |