

DATE: _____ NAME: _____

ADDRESS: _____

POSTCODE: _____

tel: _____ mobile: _____

email: _____

D.O.B: _____ CURRENT AGE: _____

DOCTOR'S CONTACT DETAILS:

Occupation: (environment/drive/stress)

Marital Status:

Children: (fertility/pregnancy/labour/prostate)

Reason for consultation:

Medication: (dosage/how long/the pill/HRT/supplements)

Medical History: (operations/accidents/illnesses/vaccinations)

	<i>Worse at time of day</i>
Skeletal	
Muscular	
Respiratory	
Sinus	

Height: _____ Weight: _____

Mental Health History: (depression, anxiety, mood swings, panic attacks)

Do you wear contact lenses or spectacles? (what type/shortsighted/longsighted)

Do you use any other type of therapy/see other therapists (complementary or orthodox)

Sleeping Pattern: (insomnia, nightmares, snoring)

Fears or Phobias:

Current Stress or Worry:

How do you feel in yourself?

Do you know anything about kinesiology?

Any other notes: