



KAYLENE ROLLIN

KINESIOLOGY & MASSAGE

## CONFIDENTIAL CLIENT INFORMATION FORM

### Personal Details

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ DOB: \_\_\_\_\_  
Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Email: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Gender: ☐ Male ☐ Female  
Health Fund: \_\_\_\_\_ Referred by: \_\_\_\_\_  
Have you seen a Kinesiologist before? ☐ Yes ☐ No

### Emergency Contact Details

Next of Kin (name): \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

Parent or Guardian consent for a minor (if applicable)

I give informed consent for \_\_\_\_\_ aged \_\_\_\_\_ years, to have a Kinesiology session with Kaylene Rollin. Signed: \_\_\_\_\_ Date: \_\_\_\_\_

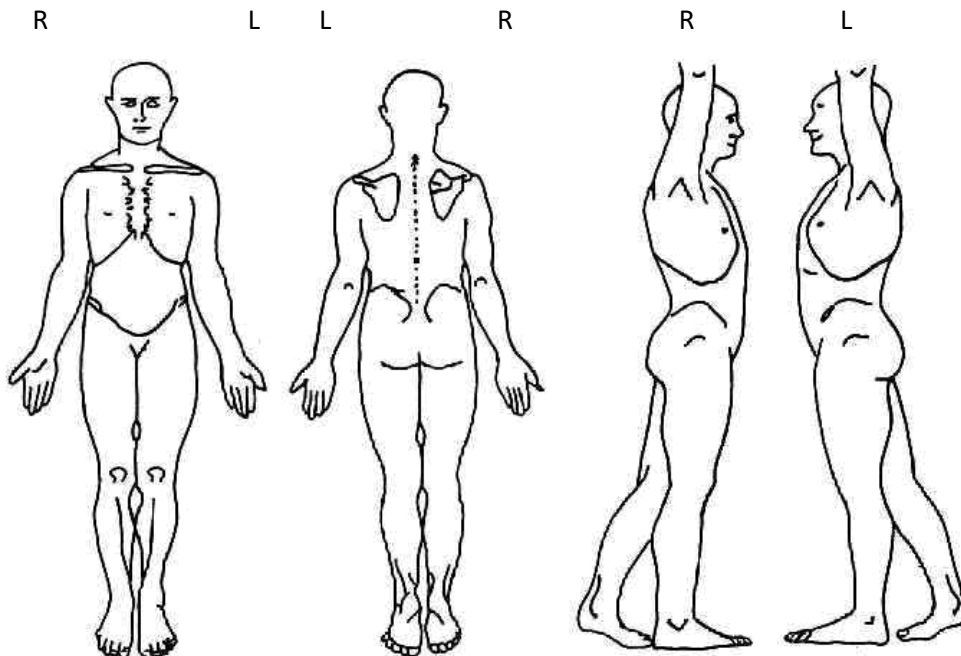
Are you currently under the care of a health professional? ☐ Yes ☐ No

- ☐ Osteopath ☐ Chiropractor ☐ Physiotherapist ☐ General Practitioner  
☐ Counsellor ☐ Psychologist ☐ Natural Therapist \_\_\_\_\_  
☐ Other Health Professional \_\_\_\_\_

Current Medical Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Presenting Symptoms:

Details/Observations:





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Please indicate any injuries, illnesses or medical conditions:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Musculoskeletal condition | <input type="checkbox"/> Chronic Pain                    | <input type="checkbox"/> Osteoporosis               |
| <input type="checkbox"/> Muscle tension / cramps   | <input type="checkbox"/> Numbness / tingling             | <input type="checkbox"/> Scoliosis                  |
| <input type="checkbox"/> Sprains / Strains         | <input type="checkbox"/> Broken Bones                    | <input type="checkbox"/> Dislocations               |
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Painful joints                  | <input type="checkbox"/> Joint replacement          |
| <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Migraines                       | <input type="checkbox"/> TMJ Syndrome               |
| <input type="checkbox"/> Tiredness / fatigue       | <input type="checkbox"/> Dizziness / vertigo             | <input type="checkbox"/> Skin Condition             |
| <input type="checkbox"/> Cardiovascular condition  | <input type="checkbox"/> Haemophilia                     | <input type="checkbox"/> Lymphatic condition        |
| <input type="checkbox"/> Heart Condition           | <input type="checkbox"/> Thrombosis / clots              | <input type="checkbox"/> Poor circulation           |
| <input type="checkbox"/> Varicose Veins            | <input type="checkbox"/> High / Low Blood Pressure       | <input type="checkbox"/> Phlebitis                  |
| <input type="checkbox"/> Respiratory condition     | <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Cold / flu / fever         |
| <input type="checkbox"/> Immune system condition   | <input type="checkbox"/> HIV                             | <input type="checkbox"/> Infectious condition       |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Dental condition           |
| <input type="checkbox"/> Tinnitus                  | <input type="checkbox"/> Hearing impairment              | <input type="checkbox"/> Visual impairment          |
| <input type="checkbox"/> Nervous system condition  | <input type="checkbox"/> Neck or Spinal injury           | <input type="checkbox"/> Epilepsy / Seizures        |
| <input type="checkbox"/> Reproductive condition    | <input type="checkbox"/> Pregnancy How many weeks? _____ | <input type="checkbox"/> Miscarriage                |
| <input type="checkbox"/> PMS syndrome              | <input type="checkbox"/> Endocrine condition             | <input type="checkbox"/> Insomnia                   |
| <input type="checkbox"/> Depression                | <input type="checkbox"/> Anxiety                         | <input type="checkbox"/> Psychological condition    |
| <input type="checkbox"/> Digestive condition       | <input type="checkbox"/> Constipation / Diarrhea         | <input type="checkbox"/> Kidney / Urinary condition |

☐ Other conditions / illnesses that would be important for me to know about:

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☐ Allergies: \_\_\_\_\_

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☐ Surgery or Hospitalisation \_\_\_\_\_

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☐ Recent Injuries / accidents / falls \_\_\_\_\_

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Reason for visit:

Desired outcome:



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Marital status: \_\_\_\_\_ Partners name: \_\_\_\_\_

Children: ☐ Yes ☐ No

Name _____	Age: _____	<input type="checkbox"/> male	<input type="checkbox"/> female
Name _____	Age: _____	<input type="checkbox"/> male	<input type="checkbox"/> female
Name _____	Age: _____	<input type="checkbox"/> male	<input type="checkbox"/> female
Name _____	Age: _____	<input type="checkbox"/> male	<input type="checkbox"/> female

Are you currently taking any medication: ☐ Yes ☐ No

Medication	Dosage	Length of time	Condition it is treating

Are you currently taking any supplements : ☐ Yes ☐ No

Supplements – vitamin / mineral / other	Dosage	Length of time	Reason for taking it

Indicate your general diet preferences:

<input type="checkbox"/> Meat and veg	<input type="checkbox"/> Vegetarian	<input type="checkbox"/> Vegan	<input type="checkbox"/> High protein
<input type="checkbox"/> Macrobiotic	<input type="checkbox"/> High protein	<input type="checkbox"/> Wheat free	<input type="checkbox"/> Gluten free
<input type="checkbox"/> Dairy free	<input type="checkbox"/> Other _____		

Indicate daily intakes of:

Sugar (t/spoons) _____	Coffee (cups) _____	Tea (cups) _____
Alcohol (drinks) _____	Water (glasses) _____	Other: _____

Food allergy / intolerance: ☐ Yes ☐ No Details: \_\_\_\_\_

Additional Dietary information: \_\_\_\_\_

Do you exercise: ☐ Yes ☐ No How often per week: \_\_\_\_\_ Duration: \_\_\_\_\_

Type of exercise: \_\_\_\_\_

Average number of hours sleep per night: \_\_\_\_\_ Difficulty sleeping? ☐ Yes ☐ No \_\_\_\_\_

Do you smoke: ☐ Yes ☐ No Number per day \_\_\_\_\_ How long have you smoked: \_\_\_\_\_

Do you take any recreational drugs? ☐ Yes ☐ No Frequency: \_\_\_\_\_

Body Piercings ☐ Yes ☐ No Tattoos ☐ Yes ☐ No Major scars ☐ Yes ☐ No



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Details of major childhood illness:

Age	Illness

Details of family health history:

Relation	Current or past condition

Number of siblings: \_\_\_\_\_ Your place in family: \_\_\_\_\_

**Declaration:** I declare that the above information is true and correct. I understand that it is my responsibility to inform the therapist of any changes to medication and major illnesses or conditions in subsequent visits. I understand and accept that Kinesiology is a complimentary therapy and is in no way diagnostic or curative. I understand and accept that the results of the treatment are not guaranteed in any way. I understand and accept that any personal information I provide in the Confidential Client Information Form and notes made by the therapist in my Session Records, will remain the property of the clinic and will be securely stored and kept in strict confidence. I am aware that I may request in writing, to view or access copies of the records detailing my personal information, which is held by the clinic. I understand and accept that my written permission is required to provide consent to any records that detail my personal information, being disclosed to any other party. I am also aware that I am able to view the Privacy Policy of the clinic at any time. I understand and accept the Clinic Policies regarding late attendance, non-attendance and cancellation and understand that non-attendance or cancellations made within 24 hours will incur a 50% charge of the session fee.

☐ I consent to receiving direct marketing from the clinic regarding updates to the services provided, via email or text.

Name: \_\_\_\_\_ Signed: \_\_\_\_\_ Date: \_\_\_\_\_