Marika Morley, BSc Kin

Kinesiology New Patient Form

CONFIDENTIAL

Name:	Legal Name:
Date of Birth:	Occupation:
Address:	
Email:	Phone:
Emergency Contact (name & phone):	

Main Concerns

Briefly describe the health concerns you would like resolved:

When did it start?

Do you consider your health concerns to be:

- ☐ Severe
- ☐ Moderate
- ☐ Quite Severe
- ☐ Mild

What other forms of therapy have you used to resolve your health problem(s)?

- ☐ Doctor
- ☐ Osteopathy
- ☐ Acupuncture
- ☐ Chiropractor
- ☐ Diet
- ☐ Supplements
- ☐ Physiotherapy
- ☐ Exercise
- ☐ Naturopathy
- ☐ Other

Health History

Do you have any specific illness or problems recurring from time to time? (ie rashes, premenstraul pain, insomnia, migrains, constepation, incontinence, infections, coughs/colds etc.)

Do you have any ongoing disease(s)? (ie asthma, hypertension, diabetes, cancer, heart disease, ulcers, etc.)

Please list any previous illnesses, accidnets, or surgery that you have had and the year in which it occured:

Current Health Status

Do you take any of the following?

- ☐ Herbs
- ☐ Alcohol
- ☐ Food Additives
- ☐ Flower Essences
- ☐ Processed Foods
- ☐ Amino Acids
- ☐ Artificial Sweeteners
- ☐ Anti-oxidants
- ☐ Birth Control
- ☐ Medication
- ☐ Minerals
- ☐ Homeopathics
- ☐ Coffee
- ☐ Antacids
- ☐ Vitamins

Please specify any medications, herbal medicine, or supplements you are currently taking:

Do you have allergies?

- ☐ Yes
- ☐ No

If yes, please spcify allergens:

How often do you exercise?

- ☐ Daily
- ☐ Weekly (2-4x)
- ☐ Occasionally
- ☐ Never

What is your daily energy level?	What time do you go to bed?	What time do you wake up?	What is your sleep quality?
1 ---------- 5 ---------- 10			1 ---------- 5 ---------- 10

Are there any problems or stress factors in your life at the moment?	My stress levels are:			
	☐	High	☐	Middling
	☐	Quite High	☐	Low
	My current living situation is:			
	☐	Very Good	☐	Not Good
	☐	Good	☐	Poor

Relaxation/Meditation:				Are you a smoker?		Were you a smoker?	
☐	Daily	☐	Occassionally	☐	Yes	☐	Yes
☐	Often	☐	None	☐	No	☐	No

Do you use orthordics in your shoes?	Do you experience:									
☐	Yes	☐	Back pain	☐	Rining in ears	☐	Facial pain	☐	Shoulder pain
☐	No	☐	Neck pain	☐	Clicking of jaw	☐	Knee pain	☐	Hip pain

Menses

Are you pregnant?	If yes, how advanced?	Duration of cycle (No. of days) and age of first menses:
☐ Yes		
☐ No		

Duration of Menses (Regularity):						If other, please specify:
☐	Regular	☐	Iregular	☐	Heavy	
☐	Painful	☐	Menopausal	☐	Other	

Personal Health Conerns

Please tick any of the following issues which relate to you:

☐	Nervousness	☐	Depression	☐	Pain	☐	Repetitive thoughts	☐	Sexual problems
☐	Suicidal thoughts	☐	Anxiety	☐	Dizziness	☐	PMS	☐	Drug use
☐	Alcohol use	☐	Anger	☐	Lack of self control	☐	Parenting/children	☐	Unhappiness
☐	Stress	☐	Poor work-life	☐	Lack of relaxation	☐	Low motivation	☐	Tiredness
☐	Infertility	☐	Poor memory	☐	Low energy	☐	Grieving	☐	Insomnia
☐	Lonliness	☐	Poor concentration	☐	Sleep apnoea			☐	Headaches
☐	Tinnitus	☐	Joint pain	☐	In school				

Family History

Do diseases such as diabetes, hypertension, cancer, arthritis etc occur in your your family? If yes, please give details:

☐ Yes

☐ No

Do you have a support person/group?	If yes, please give details:
☐ Yes	
☐ No	