

## Client Intake

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Prov:** \_\_\_\_\_ **Postal code:** \_\_\_\_\_

**DAY PHONE:** \_\_\_\_\_ **MOBILE:** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

How did you hear about us? \_\_\_ Website, \_\_\_ Referral \_\_\_ who may we thank? \_\_\_\_\_

. . . . .

Occupation \_\_\_\_\_ Are you currently pregnant: Y / N

Family situation: \_\_\_ Single \_\_\_ Living alone/roommate \_\_\_ Living with parents \_\_\_ Living with partner

\_\_\_ Married \_\_\_ Separated \_\_\_ Other

\_\_\_ Children: how many \_\_\_\_\_ ages \_\_\_\_\_

What other treatments are you having? \_\_\_\_\_ have tried? \_\_\_\_\_

**Do you suffer from any of the following: Please check and write C (current) or P (past)**

Acid Reflux	Cholesterol	High Blood Pressure	Pain: back, neck, shoulders
Acne	Constipation	HIV/Aids	Pain: joints
ADD/ADHD	Crohn's Disease	Indigestion	Pain: muscles
Addictions	Depression	Infertility	PMS
Allergies	Diabetes/hypoglycemia	Insomnia	Poor Circulation
Anxiety/Anxiety Disorder	Diarrhea	Irritable Bowel Syndrome	Prostate
Arm/hand numbness	Diverticulitis	Kidney Infection	Repeated infections
Arthritis	Dizziness	Kidney Stones	Runny eyes or nose
ASD/autism/aspergers	Dyslexia	Lack of Concentration	Seizures
Asthma	Eczema	Learning disabilities	Sinus stuffy/ problems
Back problems	Endometriosis	Liver Problems	Skin Problems/Rash/Hives
Bipolar/other mental illness	Fainting	Low Blood Pressure	Sleep
Bladder Infection	Fatigue/Low Energy	Low Immunity	Sore throat
Bronchitis/Respiratory	Fibromyalgia	Low sex drive	Stroke
Bursitis	Food cravings	Menopausal problems	Tendonitis
Cancer	Gall Bladder Attacks	Menstrual Problems	Thyroid Problems
Candida/Yeast Problems	Genital issues	Migraines	Tinnitus/ear ringing
Canker/Cold Sores	Hay Fever	Mood Swings	Twitches/ tremors
Celiac disease	Headaches	Multiple sclerosis	Ulcers
Carpel Tunnel Syndrome	Hearing problems	Neuropathy/feet numbness	Urination
Chronic Fatigue Syndrome	Heart Problems	Osteoporosis	Vision problems
Chronic Pain	Heavy Metals		Weight Problems
Colitis	Heartburn	Other:	

Are you aware of any allergies? Please list your suspicions on what triggers you: \_\_\_\_\_

\_\_\_\_\_

Are you currently being treated for any medical conditions? \_\_\_\_\_ If yes, for what and how long?

\_\_\_\_\_

Please list any medications, herbs, vitamins or supplements you are currently taking: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any major accidents, broken bones, concussions, whiplash, sports injuries, etc.:

\_\_\_\_\_

\_\_\_\_\_

Please list any surgeries (with approx. age when done): \_\_\_\_\_

\_\_\_\_\_

Have you had major dental work done (braces, teeth removed, root canals, crowns, bridges, implants, or a lot of amalgam (silver fillings.) \_\_\_\_\_

\_\_\_\_\_

Are you happy with your weight? \_\_\_\_\_ If not, what is your ideal weight? \_\_\_\_\_

Are you on a special diet? \_\_\_\_\_ If yes, what diet? \_\_\_\_\_

Dietary restrictions, if any (religious/vegetarian/vegan/gluten-free/dairy-free, etc.)

\_\_\_\_\_

Describe a typical day's eating & drinking:

Breakfast: \_\_\_\_\_

\_\_\_\_\_

Lunch: \_\_\_\_\_

\_\_\_\_\_

Evening meal: \_\_\_\_\_

\_\_\_\_\_

Between meals: \_\_\_\_\_

Water intake (# of glasses/day): \_\_\_\_\_ Coffee/tea: \_\_\_\_\_

What do you do for exercise and relaxation: \_\_\_\_\_

\_\_\_\_\_

Do you smoke? Y/N If so, what & how many a day? \_\_\_\_\_

Do you drink alcohol Y/N If so, what & how often? \_\_\_\_\_

Do you use recreational drugs? Y/N If so what & how often? \_\_\_\_\_

If not now, have you in the past? Y/N If so what? \_\_\_\_\_

Your general state of Health is: \_\_ excellent \_\_ good \_\_ fair \_\_poor

Number of antibiotic treatments in last 5 years? \_\_\_\_\_

History of adverse reactions to immunizations Y / N reaction? \_\_\_\_\_

Are you regularly exposed to toxins or other hazards (work/home/hobbies, etc.): please describe:

\_\_\_\_\_

How would you describe the emotional climate in your home?:

\_\_\_\_\_

How stressful is your work or other aspect of your life? How do you manage the stress?

\_\_\_\_\_

List any emotional traumas/episodes, with rough dates, as far back as you like (e.g. bereavements, divorce, parents split up, abuse, etc.)\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there anything else that you feel would be important for us to know? \_\_\_\_\_

\_\_\_\_\_

. . . . .

What areas, problems or goals would you like help with now? (Please list in order of importance to you.)

\_\_\_\_\_

\_\_\_\_\_

Health Kinesiology™ is a branch of alternative medicine that incorporates bioenergetic kinesiology so that information can be gathered and monitored from the client’s energy system. By using manual muscle-testing, the Health Kinesiology™ practitioner can determine what may be stressing the energy system and how to make corrections to it. Health Kinesiology™ does not directly treat or cure any disease or condition. However, Health Kinesiology™ does work to restore the natural energy balance of the meridian system. In turn, this energy balance helps to improve the health condition of the body. Therefore, anyone with any condition can benefit from the application of Health Kinesiology™.

Thank you for taking the time to fill out this lengthy intake form. We look forward to working with you to optimize your health and well being.

***Please read and sign the informed consent that follows.***

## **Informed Consent to Treatment**

**Please read and sign the following statements:**

*I understand that I give my consent to the practitioners of East House Natural Health Centre to conduct a session of Health Kinesiology™, and/or other natural therapies such as essences, nutritional consulting, quantum healing, etc. as may be appropriate, with me.*

*I understand that the practitioners of this health centre are certified in their disciplines and will use only natural, non-invasive methods of assessment and therapy.*

*I am aware that a healing reaction (commonly called “detox reaction”) may occur. It is usually mild and will pass in a few days with rest and water. I may experience tiredness, irritation, digestive disturbances, soreness, a mild fever or other symptoms. If I have any concerns with a reaction I will contact my practitioner immediately.*

*I also understand that Health Kinesiology™ does **NOT directly treat** any physical diseases, disorders, ailments, etc. Health Kinesiology™ work is for the body’s underlying energy system.*

*I also understand that Health Kinesiology™ is **NOT** psychotherapy. It deals with emotional issues on an energy level, not a conscious level. It does **NOT** deal with, nor is it related to parapsychology.*

*I understand that Health Kinesiology™ is a complementary health program and does **NOT diagnose** disease or conditions, nor does it replace the care of your physician. It is your responsibility to consult your physician about any medical problem or concern that you become aware of.*

*I understand that any advice given to me as a client at East House Natural Health Centre is not mutually exclusive from any treatment or advice I may be given by another health care provider. I understand that I am at liberty to seek, or continue, medical care from any other health care provider qualified to practice in the province. I understand that the practitioners reserve the right to determine which cases fall outside of their scope of practice and an appropriate referral will be recommended.*

*I understand that I am accepting or rejecting this care by my own free will.*

*I understand that no employee or practitioner at East House Natural Health Centre is suggesting to me to refrain from seeking the advice of another health care provider.*

*I understand that the services offered are not covered by AHS or MSP and are payable at time of service. Submission to any insurance plan that may provide coverage for the service is my sole responsibility.*

*I understand the 48 hours notice is required for appointment cancelation; otherwise, I will be responsible for the cancelation fee of 50% of the time booked.*

*I understand that any therapies recommended will be explained to me in full by the therapist and that I will give consent to treatment based on informed consent.*

I, \_\_\_\_\_, have read, understood, and agree to the above statements.

**SIGNATURE** ( or PARENTAL GUARDIAN’S SIGNATURE)

**DATE**

**Please print Parent’s name if signing for a minor:** \_\_\_\_\_