Client History Questionnaire

First Name: _____ Surname: _____

Address: _____ Suburb: _____

Post Code: _____ Date of Birth: _____ Age: _____

Home: _____ Work: _____ Mobile: _____

Email: _____

☐ Male ☐ Female Do you have any children, if so, how many? _____

Who referred you and how did you hear about me? _____

Do you have a *Current [C]* or *Previous [P]* health or medical condition? (* Please circle appropriate answer)

Allergies *[C] [P]*	YES / NO	Asthma / Bronchitis *[C] [P]*	YES / NO
Broken Bones *[C] [P]*	YES / NO	Cancer / Tumours / Cysts *[C] [P]*	YES / NO
Cranial / Jaw / Spinal Surgery *[C] [P]*	YES / NO	Headaches *[C] [P]*	YES / NO
Heart Conditions *[C] [P]*	YES / NO	High / Low Blood Pressure *[C] [P]*	YES / NO
Muscle / Tendon / Bone Issues *[C] [P]*	YES / NO	Pregnant / Reproductive Issues *[C] [P]*	YES / NO
Seizures / Epilepsy *[C] [P]*	YES / NO	Skin Conditions *[C] [P]*	YES / NO
Spinal / Disc Injury or Condition *[C] [P]*	YES / NO	Thrombosis / Blood Clots / Aneurysms *[C] [P]*	YES / NO
Varicose Veins *[C] [P]*	YES / NO	Other: _____	

Are you a smoker? YES / NO How long? _____ How many per day? _____

Are you a drinker? YES / NO How long? _____ How many per day? _____

Other: _____

Have you had any accidents or undergone any surgery? YES / NO

If so, please explain: _____

_____

Are you on any medication? YES / NO If so, what type(s): _____

_____

Are you on antidepressants? YES / NO

- Have you ever been hospitalized or institutionalized YES / NO

Reason for consultation:

* Please tick and circle the relevant reason(s) for attending today:

- ☐ Energy
- ☐ Vitality
- ☐ Direction
- ☐ Clarity
- ☐ Certainty
- ☐ Balance
- ☐ Anxiety
- ☐ Insecurity
- ☐ Depression
- ☐ Grief
- ☐ Jealousy
- ☐ Shame / Guilt
- ☐ Loss
- ☐ Uncertainty
- ☐ Pain / Discomfort
- ☐ Anger / Rage
- ☐ Fear
- ☐ Victim mentality
- ☐ Stress (Mental / Emotional / Physical)
- ☐ Resentment
- ☐ Sadness
- ☐ Other: _____

Areas of Life:

* Please circle the appropriate numerical value for each area of life

0 = Not at all ; 10 = Extremely ; N/A = not applicable

	Stress level you have in this area of life	**Satisfaction** level you have in this area of life
Physical	N/A 0 1 2 3 4 5 6 7 8 9 10	N/A 0 1 2 3 4 5 6 7 8 9 10
Mental	N/A 0 1 2 3 4 5 6 7 8 9 10	N/A 0 1 2 3 4 5 6 7 8 9 10
Spiritual	N/A 0 1 2 3 4 5 6 7 8 9 10	N/A 0 1 2 3 4 5 6 7 8 9 10
Career	N/A 0 1 2 3 4 5 6 7 8 9 10	N/A 0 1 2 3 4 5 6 7 8 9 10
Family	N/A 0 1 2 3 4 5 6 7 8 9 10	N/A 0 1 2 3 4 5 6 7 8 9 10
Social	N/A 0 1 2 3 4 5 6 7 8 9 10	N/A 0 1 2 3 4 5 6 7 8 9 10
Financial	N/A 0 1 2 3 4 5 6 7 8 9 10	N/A 0 1 2 3 4 5 6 7 8 9 10
Vocational	N/A 0 1 2 3 4 5 6 7 8 9 10	N/A 0 1 2 3 4 5 6 7 8 9 10
Relationships	N/A 0 1 2 3 4 5 6 7 8 9 10	N/A 0 1 2 3 4 5 6 7 8 9 10
Energetic	N/A 0 1 2 3 4 5 6 7 8 9 10	N/A 0 1 2 3 4 5 6 7 8 9 10

☐ ***I understand that the Alpha Alignment Technique™ is a modality and <u>NOT</u> a form of therapy, and that <u>ALL</u> information provided is true and correct***

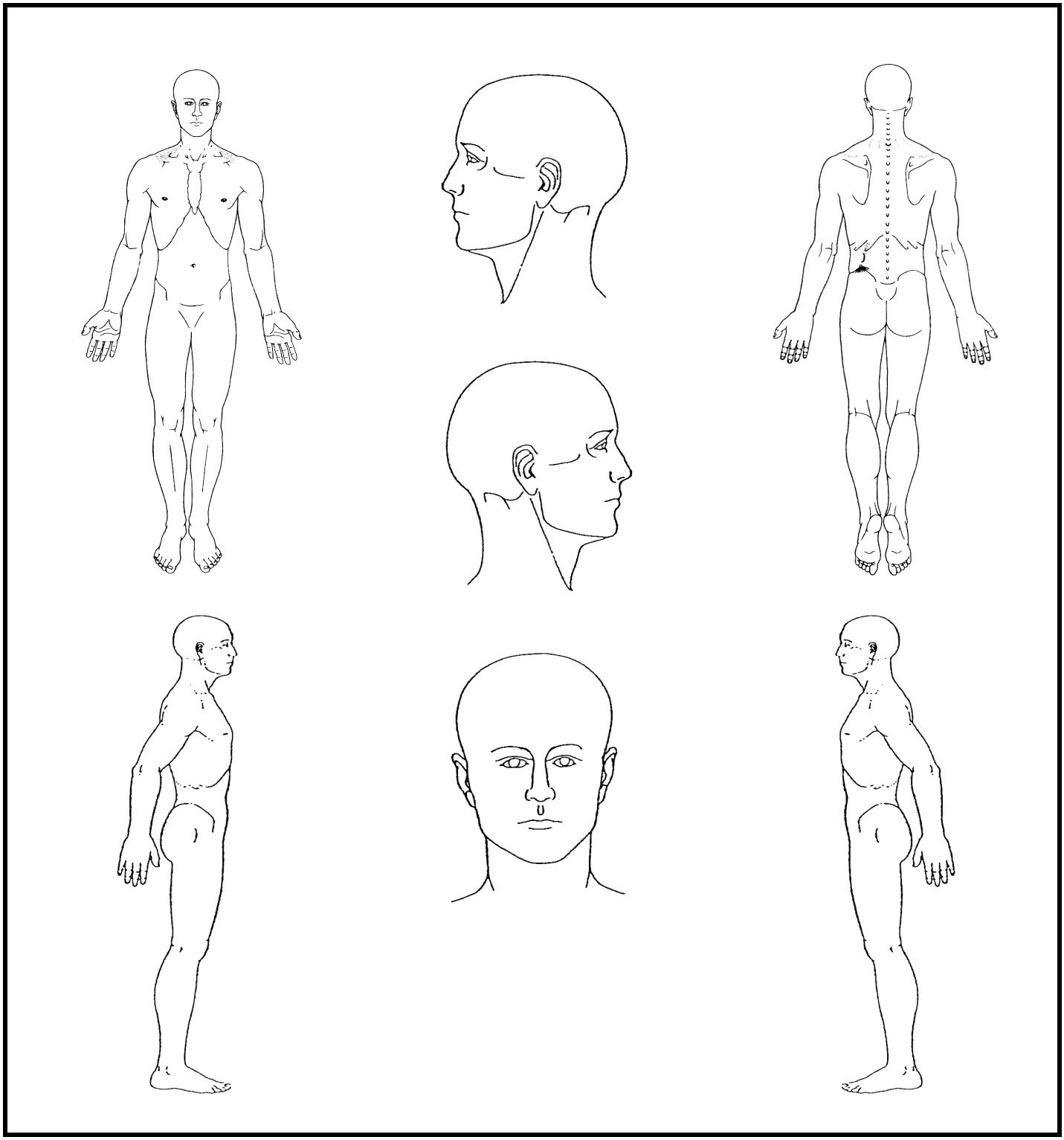
Signature: _____ Date: _____

OFFICE USE ONLY:

Notes: _____ Amount paid: _____ Next appointment: _____

REVIEW OF CONDITIONS (CONTINUED)

Please indicate where you have pain / discomfort in your body:



Notes: