CANDICE ELIZABETH
hello@candiceelizabeth.com.au
Phone: 0452 043 188
www.candiceelizabeth.com.au
ABN: 65760462710

HEALTH RECORD – CHILD / STUDENT

Please complete this form prior to your appointment and return via email to:
hello@candiceelizabeth.com.au
All information collected will remain confidential.

Date:_____

First Name:	**Surname:**
Mother's Name:	**Father's Name:**
Address:	**Contact Number** **Home:** **Work:** **Mobile:**
Email Address:	
Date of Birth: **Age:**	**Referred By:**
Family MD:	**Other Health Professional:**
Have you received Kinesiology care before: **Y / N**	**Name of Kinesiologist:** **Date of Last Visit:**
Siblings (Name, Age, Gender):	**Child's place in the Family:**
Family Health History (Heart Disease, Thyroid, Diabetes, Cancer, Other):	
Past Trauma/Accidents (date, age):	
Past Surgery (date, age):	
Childhood and Birth History:	
Current Health Concerns (inc severity, start date, cause, affect): **Sleep –** **Respiratory –** **Postural -** **Developmental –** **Nutritional –** **Behavioural -**	
Current Stressors (inc, physical, chemical, emotional):	
Current Medication:	

Current Supplements:
Food Preferences (circle one): **meat + 3 veg vegetarian vegan macrobiotic high protein** **wheat free gluten free dairy free all food other:**
Daily Intake: **Sugar: Fruit: Vegetables: Water: Juice:**
Energy Level: 0 1 2 3 4 5 6 7 8 9 10 **No energy Full of energy**
Interests/socialising/clubs:

Sports:	**Exercise:**

Self Development:
Reasons why you are here:
What would you like to have happen as an outcome of this session?
Is there anything else I should know?

Informed Consent. Release and Waiver of Liability.

Kinesiology is recognised as being an effective and safe method of care for many conditions. However, you must recognise that there are risks associated with all health care procedures. Please read the following carefully.

I agree to the following:

1. The information I have provided on this form is complete and accurate.
2. I understand that participating in a Kinesiology session may involve physical movement and energy shifting. I assume the foregoing risks and accept full personal responsibility for any personal injuries, dizziness, nausea, muscle soreness sustained by my child and discharge and hold harmless Candice Elizabeth O'Meara, its owners, directors, members, employees and agents from any claim, cause of action or liability for damages arising from any personal injury to my child or other persons or property caused by my child's participation in Kinesiology sessions. I accept that results are not guaranteed.
3. I represent and warrant that my child is physically fit and has no medical conditions that would prevent he/she from participation in Kinesiology sessions. I understand it is my responsibility to disclose to Candice Elizabeth O'Meara any historical and/or current medical conditions my child had/has.
4. I consent for Candice Elizabeth O'Meara to perform a complete postural and neurological examination on my child if necessary during a session.
5. I acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed care for my child and I give consent to proceed.
6. I hereby acknowledged my consent to the performance of the proposed Kinesiology care on my child by Candice Elizabeth O'Meara. I understand I can withdraw my consent at any time.

Signed (Client):

Child's Name:_____

Parent's Signature:_____

Date ___/___/___

Signed Kinesiologist, Candice Elizabeth O'Meara:

Signature:_____

Date ___/___/___