CONFIDENTIAL
THETAHEALING™ NEW CLIENT QUESTIONNAIRE

PERSONAL DETAILS

Name:_____ **Date:**____/____/____

Address:_____

State:_____ **Postcode:**_____**Email:**_____

Phone (H)_____ **(W)**_____ **(Mb)**_____

Date of birth:_____/_____/_____ **Gender: M/F**_____

Occupation:_____ **Marital Status:** _____

Spouse/Partner (name, age):_____ **No. of Children:** _____

You were referred by:_____ **Current Medical Doctor**_____

Other health professionals_____

REASONS WHY YOU ARE HERE

_____
_____
_____
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HEALTH HISTORY

Please √ any of the following conditions that you are currently experiencing or have experienced in the last 6 months.

Please X any conditions you may have experienced anytime in the past prior to six months.

☐ Lower back pain	☐ Dizziness	☐ Asthma
☐ Pain between shoulder blades	☐ Ringing in ears	☐ Regular colds / flu
☐ Neck pain	☐ Nervous	☐ High blood pressure
☐ Tension / Headaches	☐ Difficulty sleeping	☐ Low blood pressure
☐ Tired, fatigue	☐ Allergies	☐ Chest pain
☐ Tension across shoulders	☐ Digestive problems	☐ Heart condition
☐ Numbing/tingling in arms/hands	☐ Diarrhea	☐ Epilepsy
☐ Numbing/tingling in legs/feet	☐ Constipation	☐ Diabetes
☐ Muscle cramps/sprains	☐ Weight problems	☐ Depression

Other conditions_____

_____

Which of the above conditions is the worst?:_____

How long have you been experiencing this condition?:_____

Describe severity of the condition_____

_____

What treatments have you tried prior to today?:_____

_____

List all surgery you have had and at what age: _____

_____

_____

List any other previous illness that has not been mentioned above: _____

_____

_____

Are you pregnant or is there any possibility that you are pregnant? _____

If applicable, at what stage in the pregnancy are you? _____

LIFESTYLE

How may hours do you sleep each night:_____ Time you retire:_____ Time you rise:_____

How often do you exercise: ☐ Daily ☐ Twice or more weekly ☐ Weekly ☐ Never

If applicable, what exercise do you do and the duration:_____

_____

_____

Do you smoke: Y / N_____ Number per day: _____ How long have you smoked:_____

What drugs (medical or recreational) are you currently taking (include dosage): _____

_____

_____

What vitamin or mineral supplements are you currently taking (include dosage):_____

_____

_____

Do you have any food allergies:_____

Indicate your "normal/general" diet:

☐ Meat & 3 veg ☐ Vegetarian ☐ Vegan ☐ High protein ☐ Macroboitic

☐ Wheat free ☐ Gluten free ☐ Diary free ☐ Other_____

Daily intakes of:

Sugar:_____ Coffee: _____ Tea:_____ Alcohol:_____ Water:_____(ltr)

Additional information_____

_____

DECLARATION

I declare that the above information is true and correct and indemnify your clinic of any liability for any false or misleading statements given. It is understood and accepted that the treatment received by your clinic is of remedial therapeutic nature and not of a diagnostic/curative approach. It is also understood and accepted that the results of the treatment are not guaranteed in any way and that any data or notes taken during the sessions will remain the property of your clinic as part of the case history records. In addition, I understand that a copy of any kept personal records will be made available to me within 48 hours of my request at any such time and that my personal information, unless otherwise noted by me, may be used by your clinic for notification of any future news, products or services as deemed appropriate by your clinic. I am attending your clinic of my own free will and consent and exercise my right to discuss and choose any suitable treatments available to me.

I further understand that no account is rendered by your clinic and my payment is at the time of the service and can be made either by cash or cheque. I understand and accept the cancellation policy of your clinic is 48 hours notice with a full consultation fee to be paid.

Patient's Signature (parent or guardian): _____

Patient's Name: _____

Date: _____/_____/_____