AMICAY KINESIOLOGY

PATIENT INFORMATION FORM

Name: ___________________________________ Email: ______________________________________ Date:___________

Address____________________________________ City __________________________________ST ____ Zip Code ________

Phone # (C) ____________________ (W) ____________________ (H) __________________

Age: _____ Birth date ____/____/____ SS#______-___-______ Driver Lic. #______________________

Sex: M F Marital Status: M S W D No. of Children _____ Occupation________________________________

Employer_________________________________ Work Address: ____

Emergency Contact: ____________________________ Relation: ____________________ Phone #: _____________________

Primary Physician (Name & Phone Number) ____

Referred By______________________________

Present Chief Complaint: "*What brings you into the office today?"*____

____

Previous Treatment for this complaint? ____

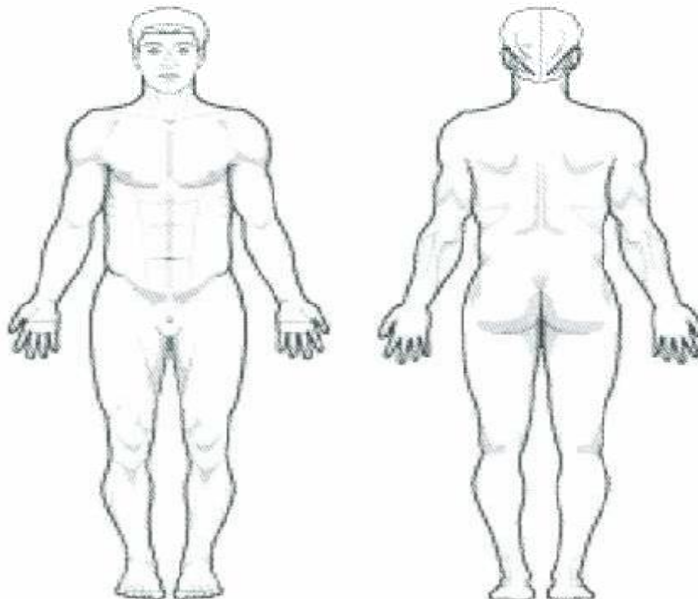
What drugs, medications, supplements, herbs, etc. are/have you been taking (past 6 months)? ______________________________

____

Are you currently under the care of a physician or other health care professionals? (If so, please give the name, contact number and date of last visit):____

Please mark area & type of pain on the drawings using the codes listed below

N-Numbness
T-Tingling
P-Pain
S-Soreness
A-Ache
ST-Stiffness



[Over]

Please check all that apply within the last six months:

General Symptoms:

- ☐ Fatigue
- ☐ Headache
- ☐ Dizziness
- ☐ Loss of Sleep
- ☐ Depression or Anxiety
- ☐ Weight loss or gain
- ☐ Anemia
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Cancer
- ☐ Allergies (please list)
- ☐ ______________________
- ☐ ______________________

Gastro-Intestinal:

- ☐ Belching/Gas/Bloating
- ☐ Abdominal Pain
- ☐ Hiatal Hernia
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Poor Appetite
- ☐ Excessive Eating
- ☐ Vomiting
- ☐ Excessive Thirst
- ☐ Indigestion

Eyes/Ears/Nose/Throat:

- ☐ Earache
- ☐ Ringing in the Ears
- ☐ Frequent Colds
- ☐ Hay Fever
- ☐ Nosebleeds
- ☐ Eye Pain
- ☐ Poor Vision
- ☐ Sinus Problems
- ☐ Hoarseness
- ☐ Sore Throat

Respiratory:

- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Spitting Blood/Phlegm
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Wheezing
- ☐ Asthma

Muscles/Joints/Bones:

- ☐ Backache
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Swollen Joints
- ☐ Foot Problems
- ☐ Hernia
- ☐ Shoulder Problems
- ☐ Tremors/Twitching
- ☐ Spinal Curvature (Scoliosis)
- ☐ Painful Joints
- ☐ Muscle Aches / Soreness

Cardio-Vascular:

- ☐ High/Low Blood Pressure
- ☐ Chest Pain
- ☐ Poor Circulation
- ☐ Rapid/Slow Heart
- ☐ Swollen Ankles
- ☐ Varicose Veins
- ☐ Previous Heart Problems

Genito-Urinary:

- ☐ Bed Wetting
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Kidney Infection
- ☐ Painful Urination
- ☐ Decreased Urine Flow
- ☐ Prostate Problems

Skin or Allergies:

- ☐ Boils
- ☐ Bruising Easily
- ☐ Dryness
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hives
- ☐ Sensitive Skin

Women Only:

- ☐ Cramps
- ☐ Excessive Flow
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Miscarriage
- ☐ Painful Periods
- ☐ Vaginal Discharge
- ☐ Lump in Breast
- ☐ Pregnant

Neurologic

- ☐ Weakness
- ☐ Twitching
- ☐ Tremors
- ☐ Headache
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Epilepsy/Seizures
- ☐ Numbness/Tingling
- ☐ Arm/Leg Pain
- ☐ Mental Disorders

Skin

- ☐ Itching
- ☐ Bruising Easily
- ☐ Change in Mole(s)
- ☐ Skin Cancer
- ☐ Scars Location

Family history of serious illness (check those that apply):

- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Multiple Sclerosis
- ☐ Lupus
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Kidney Disease
- ☐ Seizures / Strokes
- ☐ Autoimmune Disorders
- ☐ Other:_____________

Habits: (check all that apply)

- ☐ Smoking (packs/day)_____
- ☐ Caffeine (cups/day) _____
- ☐ Alcohol (days/week) _____

Exercise: (check one box)

- ☐ None
- ☐ Light activity
- ☐ Moderate activity
- ☐ Active
- ☐ Very active
- ☐ Elite Athlete

Please read before signing:

I authorize the health care personnel of this office to evaluate the information I have provided them and the information they will further gather to consider various options available to me to improve my health, vitality and well-being and not for the treatment, or “cure” of any disease.
I specifically authorize the health practitioner at Amicay Kinesiology to perform Kinesiology muscle testing analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or “cure”, of any disease.
I understand that Kinesiology muscle testing is a safe, non-invasive, natural method of analyzing the body’s physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems. I understand that Kinesiology muscle testing is not a method for “diagnosing” or “treating” any disease including conditions on cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated.
I give the office staff permission to contact me by phone, mail, email or fax to discuss with me or inform me about what might be helpful for me.

I understand this permission to contact me can be rescinded by me at any time* I choose.

____

Signed Date (If minor, signature of parent or guardian required)

*Rescinding of permission accepted in writing