Kokoro Clinic — Health Questionnaire & Consent Form

Forename:

Surname:

TITLE ……….. FORENAME ………………………………………………… SURNAME ……………………………………………………………….

ADDRESS ……

………

Mobile No …………………………………………………………………… Daytime No …………………………………………………………

E-mail ……………………………………………………………………………. D.O.B. ……………………………………… AGE ………………………

OCCUPATION/ACTIVITIES ………

Other Interests/Hobbies/Activities ……………………………………………………………………………………………………….

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Relatives also treated …………………………………………………… Referral ……………………………………………………………

GP Name & Address ………

GP/Consultant Diagnosis ……

………

Medication & Supplements ……….

………

Insertions (pins/plates/orthotics/dentures/prostheses/lenses etc.) …………………………………………………………………

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Physical traumas/injuries/accidents including client's own birth ………………………………………………………………………

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Relevant imaging details/radiology reports ………………………………………………………………………………………………

Previous treatment/manipulation/therapies ………………………………………………………………………………………………

………

General anaesthetic—incl when & why ……………………………………………………………………………………………………

Dental work ……

Headaches/Migraine ………

Stroke/TIA/Dizziness/Fainting/Balance ………………………………………………………………………………………………….

Other Investigations/Procedures ……

………

No of Pregnancies …………… No of Children ……… Details of birth(s) & dates if relevant ……………………………………………

………

Details of other children cared for by client ……………………………………………………………………………………………

Past/Current Illnesses…….

………

Allergies/Food Intolerance ……….

………

LIFESTYLE

Daily Water Intake 0--250ml ☐ 500ml ☐ 1 Litre + ☐

Do you drink tea/coffee (indicate cups per day) ....

Do you drink alcohol (indicate units per week) ....

Do you smoke (if yes, how many per day) ....

Do you exercise ....

....

Sleep Pattern/Emotional Health/Tiredness/Energy Levels ....

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Social History e.g. Dependants, bereavements, family circumstances, stress, emotional trauma ....

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Family History (incl incidence of client's symptoms in the family) ....

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Is there any other information you wish to provide ....

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DESCRIPTION OF CONDITION

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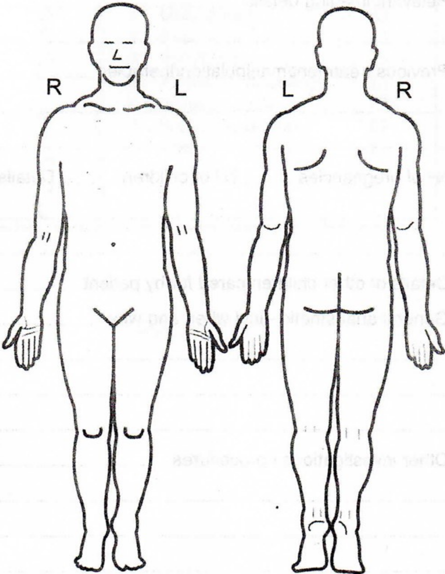

Mark the box with **X** and give details if there is a **current** problem. If no problem in a section, circle the relevant **N**.

CARDIOVASCULAR	**N**	**GENITO-URINARY**	**N**	**GASTROINTESTINAL**	**N**	**MUSCULO-SKELETAL**	**N**
Blood Pressure		Blood		Abdominal Pain		Back Problems/Pain	
Chest Pain		Frequency		Appetite		Bone or Joint Injuries	
Circulation		Incontinence		Constipation		Bruising, Cuts, Abrasions	
Palpitations		Kidney/UTI		Diarrhoea		Elbow/Wrist Pain	
Resting Pulse		Pain		Flatulence/Wind		Hip Pain/Replacement	
Swollen Ankles		Prostate		Haemorrhoids		Knee/Ankle/Foot Pain	
Varicose Veins		Stress Incontinence		Heartburn		Joint Problems	
NERVOUS SYSTEM	**N**	**MENSTRUATION**	**N**	Indigestion		Muscle Tension	
Cramp		Abnormal Discharge		Jaundice		Neck Pain/Whiplash	
Epilepsy		Breast Tenderness		Nausea/Vomiting		Osteoporosis	
Muscular Tremor		Excessive Flow		Weight Loss/Gain		Poor Circulation	
Sense of Hearing		Irregular Cycle		**RESPIRATORY**	**N**	Shoulder Pain	
Sense of Sight		Menopause		Asthma		Thrombosis	
Sense of Smell		Pain/Cramps		Breathing Difficulty		Varicose Veins	
Sense of Taste		PMS		Catarrh		**SKIN**	**N**
Sense of Touch		**CANCER**	**N**	Chronic Cough		Acne	
GLANDULAR	**N**	Cysts		Sinus		Athletes Foot	
Diabetes - Type 1		Fibroids		Smoker		Eczema	
Diabetes - Type 2		Other		URI		Psoriasis	
Thyroid		Tumours				Skin Eruptions	

STATEMENT AND CONSENT OF CLIENT

DATA PROTECTION AND CONFIDENTIALITY

I declare that all of the aforementioned information is true to the best of my knowledge.

I understand that Total Body Modification (TBM) and Amatsu use touch and mobilisation. I agree that the Practitioner may hold and move my body to facilitate the treatment.

I agree that the TBM/Amatsu Practitioner, in accordance with the Data Protection Act, 1998 may hold and process the personal data on this form and any further data relating to my treatment. All information will be treated as strictly private and confidential and will not be shared with any other third parties without my consent.

Should consultation or referral be necessary, the Practitioner will obtain my permission before disclosing any information. The Practitioner will keep written or computer generated notes of my individual treatments. These notes are kept as a single case file. Should I require a copy at any time it will be necessary to levy a charge to cover the costs of reproduction.

I understand that failure to keep an appointment or provide 24 hours notice of cancellation will result in the full fee being charged.

Client Signature ………………………………………………………………………… **Date** ……………………………………………………

Print Name …………………………………………………………………………

If a legal guardian, state relationship to the patient ……………………………………………………………………………………

DATE	RECORD OF REACTIONS, PROGRESS, ADVICE OR OTHER INSTRUCTIONS GIVEN AND TESTS PERFORMED

TBM
Total Body Modification