The Acceleration Institute for Natural Therapists

INITIAL CONSULTATION FORM

Full Name:_____ D.O.B_____ Age:_____
Address:_____
Suburb/Post Code: _____
Phone Home/Work/Mobile: _____
Emergency Contact Name/Number/Email: _____
Email Address: _____
Occupation:_____
Children? Y/N Name/s
Ages:_____

Who Referred you? _____
Have you seen a Kinesiologist before? Y/N What did you like? _____
What do you feel you needed that you didn't get in your last session?

List of Traumas:

List of any missing organs/body parts – including teeth:

Please indicate main areas of concern holding pain/tension physically. S.U.D.S levels
Describe the pains – e.g. sharp, chronic, shooting, burning etc._____
Do these pains impact anywhere else in your body? _____
What aggravates/makes it better? _____
How long have you had the issue? _____
How does this interfere with your life currently?

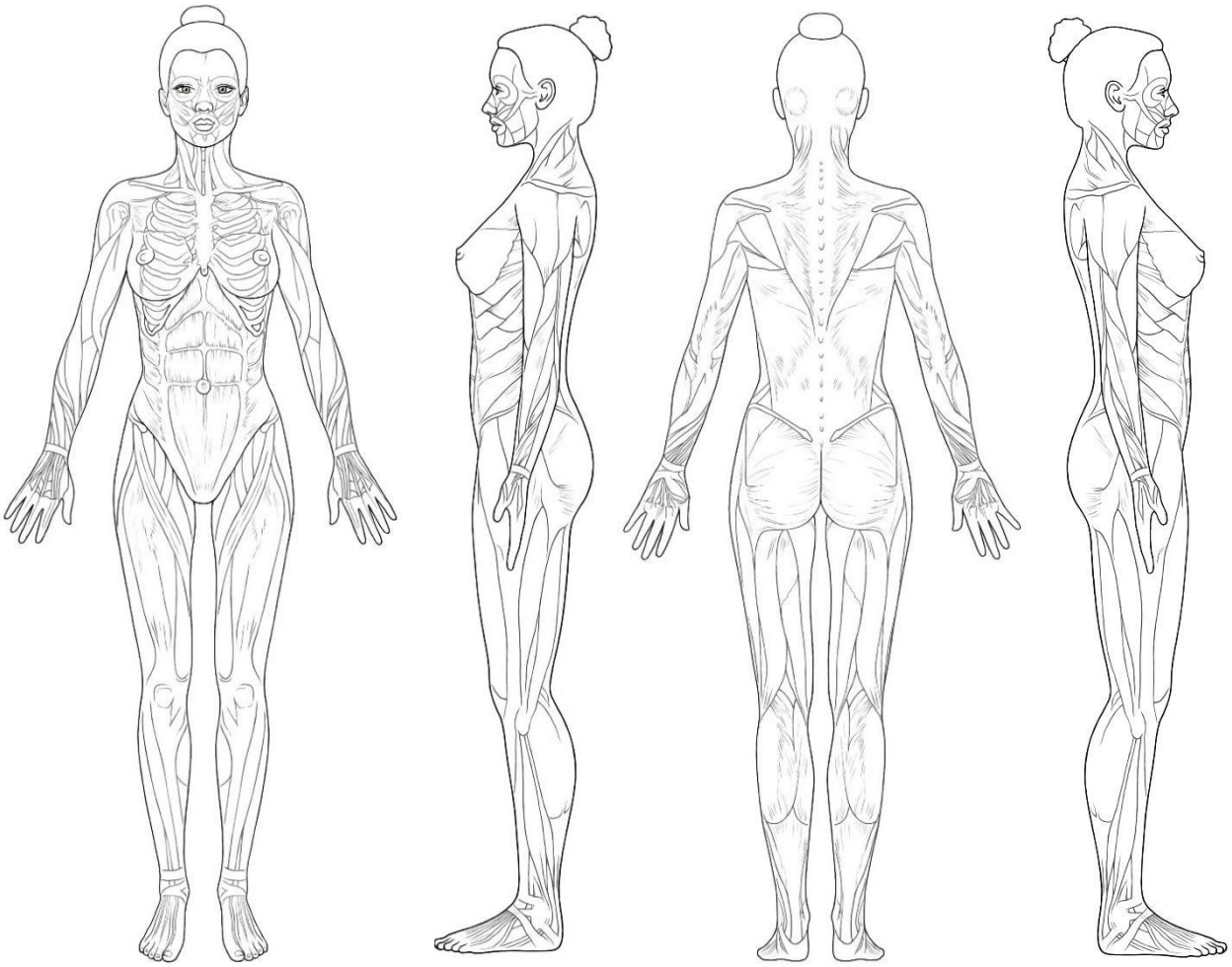
By signing this you understand consultation by us and Kinesiology does not treat, cure or diagnose it ONLY balances energy.

You understand that it is vital you see a duly licensed medical practitioner for all health concerns.

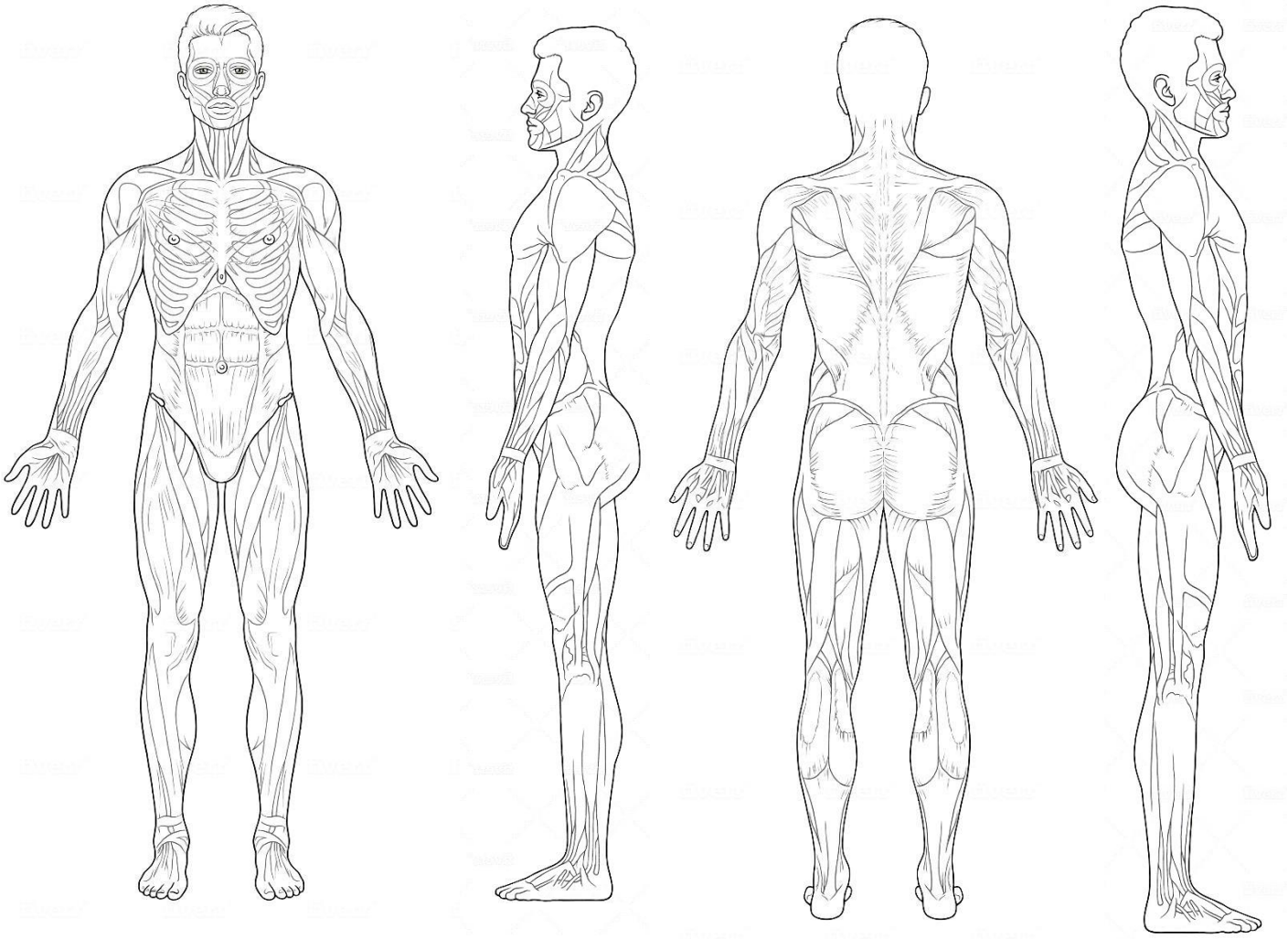
All data you have given is true and correct.

Name:_____ Signed:_____ Date: _____

BODY MAP + POSTURAL ASSESSMENT FEMALE



NOTES: **Please circle any areas of concern**



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