MASTER'S DESIGN
HOLISTIC HEALTH SOLUTIONS

Client Information

Name: ____________________________________Age: ______ Sex: M F DOB________ Date______________

Problems you would like to address:

____

____

What are your present symptoms?

____

____

Where on your body to you feel physical discomfort?

____

____

Due to your condition, have you lost time from the following?

(Describe how much time and what tasks have been limited)

Work: □Yes □No Describe: ____

Family: □Yes □No Describe: ____

Leisure Activities: □Yes □No Describe: ____

List serious sicknesses or operations: ____

Been knocked unconscious, whiplash, concussion, hit in head? _____________________________________

Any family history you feel contributes to your current health? ____________________________________

____

Medications/ Vitamins/Pacemakers:

____

____

Food allergies/sensitivities if known____

Do you consume the following? Yes or No/How Often?

Sugary foods ____

Bread ____

Coffee____

Energy Drinks____

Dairy Products ____

Servings of vegetables per day ___________________

Servings of fruits per day_________________________

What is your typical diet? ____

Current Weight: ___________________________________ Ideal Weight: _______________________________

Do you have any scars, tattoos, or piercings? ____

Do you consume alcohol, nicotine or drugs of any kind? If so, what type? _______________________________

Are you regularly exposed to second hand smoke? ____

What are your relaxation habits? ____

What are your sleep habits? ____

What are your exercise habits? ____

Rate yourself from 1-10 on your:: nutrition habits ___________________hydration habits __________________

Have you experienced any trauma? (physical or emotional) If yes, please describe, including date and age, if comfortable ____

____

____

Do you live a stressful lifestyle? If yes, what do you currently do for stress management? __________________

____

What is your typical reaction to stress? (strong emotion, tight muscles, sick stomach, etc.)__________________

____

Do you feel like you have good emotional regulation? ____

Are you involved in any toxic/unhealthy relationships? ____

Do you have any support networks? If so, please explain ____

____

On a scale of 1-10 (1=least) (10=best), how important is your health to you? ____________________________

Signature: ____Date: ______________

I would like to know:

Do you have any prior experience with Energy Kinesiology? ____

Do you have any prior experience with Nutrition Response Testing? _________________________________

How did you hear about Master's Design Holistic Health Solutions? ___________________________________

COMPLETE THIS SECTION IF YOU ARE SEEKING HELP FOR LEARNING DIFFICULTIES

MOTHER'S PREGNANCY

Physical or emotional trauma experienced by the mother during pregnancy? ____________________________

Severe illnesses or drugs taken during pregnancy? ____

CLIENT'S BIRTH

Difficulty in the birthing process or immediate post-natal period? _____________________________________

Caesarian or natural birth? ____________________________Delivery Premature? ________________________

Baby removed for a period before presentation to you? ____

CLIENT'S DEVELOPMENT

Crawl normally or army crawl? ____

Verbal language delay? ____

Other areas of late development? ____

CLIENT'S CHILDHOOD

Receive Vaccinations? ____

Sensitivity to touch, sound, taste, smell, sight? ____

Wet the bed after the age of 5? ____

Any of the following: knocked unconscious, whiplash, concussion, hit in head? __________________________

List any previous interventions tried (occupational therapy, eye therapy, etc.) __________________________

____

Behavioral Checklist:

- ☐ Clumsy
- ☐ Rubs eyes a lot
- ☐ Gets fatigued when reading
- ☐ Has anxiety over reading
- ☐ Letter/number reversal
- ☐ Poor hand/eye coordination
- ☐ Poor balance
- ☐ Poor at rhythmic activities
- ☐ Difficulty sounding out words
- ☐ Mispronounces common words

- ☐ Misses lines/looses place when reading
- ☐ Zones out/daydreams
- ☐ Low self-esteem/low confidence
- ☐ Difficulty reading out loud
- ☐ Difficulty putting thoughts into words
- ☐ Misunderstands jokes or abstract information
- ☐ Difficulty following multi-step directions
- ☐ Difficulty telling a story in the right order
- ☐ Pauses before answering questions
- ☐ Gets confused in noisy places
- ☐ Language or speech delays
- ☐ Poor organizational skills
- ☐ Easily distracted
- ☐ Emotionally sensitive
- ☐ Difficulty budgeting time
- ☐ Difficulty concentrating
- ☐ Difficulty telling time
- ☐ Trouble remembering months of the year
- ☐ Trouble remembering left/right
- ☐ Trouble remembering multiplication tables
- ☐ Impulsive
- ☐ Unable to follow thru on a task
- ☐ Has mood swings
- ☐ Has trouble sitting still/fidgets
- ☐ Short attention span
- ☐ Slow in completing work
- ☐ Stops in the middle of a game
- ☐ Poor reading comprehension
- ☐ Poor reading skills
- ☐ Poor spelling
- ☐ Fears (explain)____

Other____