

☆ IN CONFIDENCE ☆

Pre Session Questionnaire Male



Please fill out the following questions as much as you can prior to your session. By being honest ensures the most optimus results, therefore please disclose anything that could potentially cause any harm so that precautions can be taken to minimise this. Ideally if you could please email it back to mandy@optimustruebeing.com.au, or if your computer is not playing nicely, then you can bring it along with you to your first session. Many Thanks ☺

Name:

DOB:

Date:

What are the main reasons for the consultation? Problems/pains/issues? (Rate pain 1=no pain, 10=max pain)

What is your Medical History? e.g. Allergic Reactions, Anxiety/Depression/Nervous/panic attacks, Arthritis (Osteo/Rheumatoid), Asthma, Bladder weakness, Blood Pressure, Bone/structural weakness/deviations, Breathing probs, Cancer, Emotional, Eye strain/pain/blotches/glasses, Headaches/Migraines, Hearing difficulties, Heart Conditions, Liver probs/Hepatitis, Muscle pain/aches, Neurological problems, Nose discomfort/dripping/sneezing, Psychiatric History, Side Effects (other treatments), Stroke, Syncope/fainting/epilepsy, etc

How was your birth?...

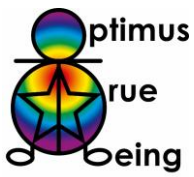
Are there any Medical difficulties within your Family? As above for Mum/Dad/Grandparents/Brothers/Sisters

What is your Digestion like? Do you open your bowels regularly? What is regular for you? Any difficulties? Reflux? bloating/pain, wind? constipation/diarrhoea?

What's your Sleeping Pattern like? How many hours sleep do you get?
(Light/Average/Heavy sleeper)
(Awake Refreshed/Tired)
(Up to the toilet @ night)

Are you on any Medications?

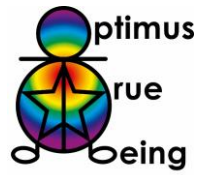
How old were you when your voice dropped?



Be the Star You Are

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Be the Star You Are

Do you get Stressed?: On an average & at extremes please rate 1=no stress, 10=max stress...
What makes you stressed? How do you feel?

Do you have any Allergies/Intolerances/Hay Fever etc?

Have you been Vaccinated? Any recent/new ones?

Do you have any Amalgam Fillings (silver)?

How is your Energy on a scale 1=no energy, 10=full of energy? When do you have most/least energy

What sort of Exercise do you do? (Type/Frequency)

How would you describe your Childhood? (Happy, Sad, Lonely, playful, fast/slow learner, etc)

Do you have any Fears? (Heights/small spaces/animals/insects/performance, etc)

Do you have any Hobbies/Interests?

Do you Dream? any vivid/repeating/nice/concerning

What is your Diet like? (Water intake, Veg, Fruit, Smoking, Drink Alcohol)

Do you take any Supplements/Herbs? Vitamins/Minerals, etc

Do you have any Food Cravings/Preferences? (Sweets/Chocolates/bitter/spicy, hot/cold, etc)

Do you smoke cigarettes? If so how many per day?

Do you use orthotic appliances in your shoes?

Do you experience back pain, neck pain or other physical pain?

Do you experience ringing in the ears, clicking/popping of the jaw or facial pain?

Anything else important?

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Please indicate any of the following issues, which relate to you and highlight those you would like to deal with...

Nervousness	Depression	Fears	Shyness
Sexual problems	Suicidal thoughts	Separation	Divorce
Finances	Drug use	Alcohol use	Friends
Anger	Self control	Unhappiness	Sleep
Stress	Work	Relaxation	Headaches
Tiredness	Legal matters	Memory	Ambition
Energy	Insomnia	Loneliness	Education
Concentration	Making decisions	Temper	Nightmares
Career choices	Inferiority	Marriage	Children
PMS	Unpleasant memories	Thoughts	Parenting
Pain	Enemies	Social skills	Motivation
Regrets	Anxiety	Dizziness	Grieving

If you are unsure about anything, you can contact me on... mandy@optimustruebeing.com.au, 0406 856 966, or write it down on this sheet to talk about during your session.

☺ Thank you! Be the star you are ☆, Mandy ☺