WELCOME

TO WONDERFULLY MADE KINESIOLOGY!

Thank you for choosing Wonderfully Made Kinesiology for your wellness journey. Our goal is to provide compassionate, holistic care that supports your mind, body, and spirit. This form helps us understand your health history, lifestyle, and goals so we can create a personalized care plan tailored to your needs.

Please answer the following questions as accurately as possible. All information you provide is strictly confidential and will only be used to support your care. If you have any questions, feel free to ask before completing the form.

We look forward to walking this journey of healing with you!

"True healing isn't just the absence of pain - it's the fullness of life. As sons and daughters of the King, we are called to wholeness in mind, body, and spirit." – Kimberly

Address: 600 25th Ave. S., Suite 110, St. Cloud, MN 56301

Https://faithcenteredwell.com

Call Us Now: (320) 250-6674

Email Us: Kimberly@faithcenteredwell.com

Wonderfully Made

FAITH-FOCUSED, HOLISTIC CARE

PATIENT INTAKE
FORM

Wonderfully Made
FAITH-FOCUSED, HOLISTIC CARE

Today's Date:

Patient Name: **Date of Birth:**

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

Street Address:

City: **State:** **Zip Code**

Primary Phone: **Secondary Phone:** **Email:**

Occupation: **Employer:**

Who can we thank for referring you to Wonderfully Made?:

PATIENT INTAKE
FORM

Wonderfully Made
FAITH-FOCUSED, HOLISTIC CARE

INFORMED CONSENT AGREEMENT

At Wonderfully Made Kinesiology, we believe in a holistic, faith-based approach to wellness, balance, and self-healing. Our services focus on addressing energy imbalances and promoting well-being, but they are not a substitute for medical diagnosis or treatment by licensed healthcare professionals.

Understanding Your Treatment:

- The kinesiology techniques used, including muscle testing and energy balancing, are intended to support your body's ability to heal itself.
- We do not diagnose, treat, or prescribe for any specific medical condition, illness, or disease.
- If you have a medical concern, it is recommended that you seek guidance from a licensed physician or healthcare provider.

Your Responsibility as a Client:

- You acknowledge that your participation is voluntary and that you assume full responsibility for your choices regarding your health.
- You understand that results may vary for each individual, and no specific outcomes are guaranteed.

Consent & Acknowledgment:

By signing below, I confirm that:

✓ I have read and understood this informed consent agreement.

✓ I understand that Wonderfully Made Kinesiology does not replace medical care and is not responsible for medical outcomes.

✓ I voluntarily choose to proceed with kinesiology and holistic healing services.

Patient Name (Print): _____

Patient Signature: _____ **Date:**_____

(For minors under 18, parent/guardian signature is required.)

FINANCIAL AGREEMENT & CANCELLATION POLICY

At Wonderfully Made Kinesiology, we are committed to providing personalized, holistic wellness services. To ensure fairness and availability to all clients, we require adherence to the following financial policies.

Payment Policy

- Payment is due at the time of service unless otherwise arranged in advance.
- We accept cash, credit/debit cards, HSA/FSA cards, and approved digital payments.
- Prepaid packages and memberships must be paid in full before the first session.

Cancellation & No-Show Policy

To respect everyone's time, we require a 24-hour notice for cancellations or rescheduling.

- Cancellations within less than 24 hours will be subject to a cancellation fee:
  - $30 for 20-minute sessions
  - $45 for 40-minute sessions
  - $60 for 60-minute sessions
- No-shows (missed appointments without notice) will be charged 100% of the scheduled session fee.
- Emergencies will be evaluated on a case-by-case basis at the practitioner's discretion.
  Refunds & Package Expiration
- All sales are final. Refunds are not provided for used or unused services.
- Prepaid session packages expire six (6) months from the purchase date unless otherwise stated.

By signing below, I acknowledge that:

✓ I understand and agree to the financial and cancellation policies outlined above.
✓ I authorize Wonderfully Made Kinesiology to charge the applicable fees if I cancel late or fail to show for my appointment.

Patient Name (Print): _____

Patient Signature: _____ **Date:**_____

(For minors under 18, parent/guardian signature is required.)

WONDERFULLY MADE KINESIOLOGY COMPLEMENTARY & ALTERNATIVE HEALTH CARE CLIENT BILL OF RIGHTS

Practitioner Information

- Practitioner Name: Kimberly Hansen
- Business Name: Wonderfully Made Kinesiology
- Business Address: 600 25th Ave. S., Suite 110, St. Cloud, MN
- Phone Number: (320) 250-6674
- Training & Qualifications: Kimberly Hansen is a holistic wellness practitioner trained in kinesiology, reflexology, cranial sacral therapy, and faith-based wellness coaching.

Client Bill of Rights

As a client receiving complementary and alternative health care services in Minnesota, you have the right to:

1. **Know Your Practitioner's Training & Qualifications**
    - You are entitled to receive information about your practitioner's training, experience, and scope of practice.
2. **Understand That Services Provided Are Not Medical Care**
    - Wonderfully Made Kinesiology practitioners are not licensed medical doctors and do not provide medical diagnoses, treatments, prescriptions, or advice regarding the discontinuation of medically prescribed treatments.
    - You are encouraged to seek licensed medical care for any concerns requiring a physician's care.
3. **Confidentiality of Your Information**
    - Your health information, records, and treatment details are confidential and will not be shared without your written consent, except as required by law.
4. **Know the Fees & Payment Policies in Advance**
    - A clear fee schedule will be provided, and you are entitled to a written summary of charges.
5. **Refuse or Discontinue Services**
    - You have the right to refuse or stop services at any time.
    - You may request a referral to another practitioner or licensed medical provider if desired.

WONDERFULLY MADE KINESIOLOGY COMPLEMENTARY & ALTERNATIVE HEALTH CARE CLIENT BILL OF RIGHTS

6.Receive Respectful & Courteous Treatment

- You have the right to receive care in a professional, respectful, and safe environment, free from abuse or discrimination.

*7.***Access Your Records**

- You may request copies of any records related to your care under Minnesota law (Sections 144.291 to 144.298).

8.**Know How to File a Complaint**

- If you have concerns about your care, you have the right to file a complaint with the Office of Unlicensed Complementary and Alternative Health Care Practice in Minnesota.

Complaint Contact Information:
Minnesota Department of Health
Office of Unlicensed Complementary & Alternative Health Care Practice
P.O. Box 64882, St. Paul, MN 55164-0882
Phone: (651) 201-3728
Website: www.health.state.mn.us

Client Acknowledgment & Consent

By signing below, I acknowledge that I have received, read, and understand my rights as a client under Minnesota Statute § 146A.11.

Client Name (Print): _____

Client Signature: _____ **Date:**_____

(For minors under 18, parent/guardian signature is required.)

WONDERFULLY MADE

KINESIOLOGY CONFIDENTIAL PATIENT HISTORY FORM

Wonderfully Made
FAITH-FOCUSED, HOLISTIC CARE

PATIENT INFORMATION

Full Name:

Date of Birth:

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

Address:

City:

State:

Zip Code

Phone Number:

Email Address:

Email Address:

Employer:

Emergency Contact:

Relationship to Patient:

Primary Care Physician:

Clinic Name:

Clinic Address:

Would you like to begin your session with prayer?

☐ Yes ☐ No

CURRENT HEALTH CONCERNS

Please list any current health concerns, symptoms, or conditions you are experiencing. Include how long you have had them.

What are your health/wholeness goals?

Are any of your current health challenges related to an injury or accident?

☐ Yes ☐ No

If yes, please explain:

Primary Sources of Stress

(Check all that apply and describe below)

- ☐ Physical (pain, injury, illness)
- ☐ Financial (job stress, debt, financial insecurity)
- ☐ Work-related (burnout, toxic environment)
- ☐ Mental/emotional (anxiety, depression, grief)
- ☐ Spiritual (faith crisis, disconnection)
- ☐ Work-related (burnout, toxic environment)

Please describe:

Medication & Supplement List

Please list all medications, vitamins, herbs, or supplements you take regularly (or attach a separate list).

Name	Dosage	Reason for Use

Do you have any allergies?

☐ Yes ☐ No

If yes, please list them:

Have you been exposed to chemicals or toxins due to lifestyle or work?

☐ Yes ☐ No

If yes, please describe:

Lifestyle Questions

Do you drink alcohol?

☐ Yes ☐ No

If yes, how often? ☐ Occasionally ☐ Weekly ☐ Daily

Do you use tobacco or nicotine?

☐ Yes ☐ No **If yes, type and amount per day:** _____

Do you exercise regularly?

☐ Yes ☐ No **If yes, describe:** _____

Do you use hearing aids?

☐ Yes ☐ No

Have you ever experienced sexual abuse?

☐ Yes ☐ No **If Yes, Age(s) of abusee?** _____

Do you experience headaches or migraines?

☐ Yes ☐ No **If Yes, Frequency:** _____

Have you ever been in a car accident?

☐ Yes ☐ No **If yes, when and describe:** _____

Have you ever received chiropractic or alternative health care treatments?

☐ Yes ☐ No **If yes, list practitioners and treatments:**_____

Reproductive Health Questions (Optional)

- ***Women Only:***

Age/Date your period started: _____

Age/Date your period stopped (if applicable): _____

Number of Pregnancies: _____ **Number of Children:** _____

Number of Miscarriages: _____ **Number of Abortions:** _____

Are you currently pregnant?

☐ Yes ☐ No

Are you currently nursing?

☐ Yes ☐ No

Do you use/have you used contraceptives?

☐ Yes ☐ No **If yes, describe:** _____

Describe your menstrual cycles/menopause:

- ***Men Only:***

Age/Date of nocturnal emissions (Wet Dreams): _____

Number of Children: _____ **Children's Ages:** _____

Do you experience any sexual dysfunction concerns?

☐ **Yes** ☐ **No** **If yes, describe:** _____

Additional notes or information that did not fit in its appropriate field

Confidential Patient History Form (Continued)

Please indicate any medical conditions you have been or are currently being treated for by checking the corresponding boxes. If any of these conditions are part of your family's medical history, write "F" in the box for family.

- ☐ Acquired Respiratory Distress Syndrome
- ☐ Allergies
- ☐ Angina
- ☐ Anxiety or Panic
- ☐ Disorders Arthritis (RA, OA) Asthma
- ☐ Back injury
- ☐ Bleeding Disorders
- ☐ Bowel/Bladder Abnormalities
- ☐ Cancer
- ☐ Emphysema
- ☐ Chronic Obstructive
- ☐ Pulmonary Disease (COPD)
- ☐ Congestive Heart Failure (CHF)
- ☐ Degenerative Disc Disease (back disease,spinal stenosis, severe chronic back pain)
- ☐ Depression
- ☐ Diabetes
- ☐ Dizzy or FaintingSpells
- ☐ Epilepsy or Seizure Disorder
- ☐ Fracture
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Heart Attack
- ☐ Hepatitis A, B, C
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Immunosuppressant
- ☐ Condition or Medication
- ☐ Kidney Problems
- ☐ Liver/Gallbladder Problems
- ☐ Metal Implants
- ☐ Multiple Sclerosis
- ☐ Diabetes
- ☐ Dizzy or FaintingSpells
- ☐ Emphysema

- ☐ Nausea/Vomiting
- ☐ Osteoporosis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular
- ☐ Disease Pregnancy
- ☐ Complications Ringing in Your Ears Sexual
- ☐ Dysfunction Skin Abnormalities
- ☐ Smoking
- ☐ Special Diet Guidelines
- ☐ Stroke or TIA
- ☐ Tuberculosis
- ☐ Upper Gastrointestinal Disease (ulcer, hernia, reflux)
- ☐ Visual Impairment (cataracts, glaucoma, Macular degeneration

Additional Questions

Your type of birth (check one):

☐ VAGINAL ☐ C-SESCTION ☐ FORCEPS ☐ OTHER (explain below)

Explain any complications during your birth:

List of dental procedures (excluding regular cleanings): root canals, implants, dentures, fillings, whitening, etc.

How many times do you urinate each day? _____ During the night? _____

How many bowel movements do you have each day? _____

Musculo-SkeletalSystem

Please check all that you are currently experiencing and a check under "P" column for past issues.

✓	P		✓	P	
☐	☐	Low back pain	☐	☐	Headaches
☐	☐	Pain between shoulders	☐	☐	Muscle jerking
☐	☐	Neck problems	☐	☐	Convulsions
☐	☐	Arm	☐	☐	Forgetfulness
☐	☐	problems Leg	☐	☐	Confusion
☐	☐	Swollen joints	☐	☐	Depression
☐	☐	Painful joints	☐	☐	Gastro-Intestinal System
☐	☐	Stiff joints	☐	☐	Poor appetite
☐	☐	Sore muscles	☐	☐	Excessive hunger
☐	☐	Weak muscles	☐	☐	Difficulty chewing
☐	☐	Walking problems	☐	☐	Difficulty swallowing
☐	☐	Ruptures	☐	☐	Excessive thirst
☐	☐	Broken bones	☐	☐	Nausea
☐	☐	Nervous System	☐	☐	Vomiting food
☐	☐	Numbness	☐	☐	Vomiting blood
☐	☐	Paralysis	☐	☐	Abdominal pain
☐	☐	Dizziness	☐	☐	Diarrhea
☐	☐	Fainting	☐	☐	Constipation

Musculo-SkeletalSystem

Please check all that you are currently experiencing and a check under "P" column for past issues.

✓	P		✓	P	
☐	☐	Black stool	☐	☐	Rapid heartbeat
☐	☐	Bloody stool	☐	☐	Blood pressure problems
☐	☐	Hemorrhoids	☐	☐	Heart problems
☐	☐	Liver trouble	☐	☐	Lung problems
☐	☐	Gall bladder problems	☐	☐	Varicose veins
☐	☐	Weight issues	☐	☐	Eye, Ear, Nose, & Throat
☐	☐	Weight issues	☐	☐	Eye strain
☐	☐	System Bladder trouble Excessive	☐	☐	Eye inflammation
☐	☐	Urination Scanty	☐	☐	Vision problems
☐	☐	Urination Painful	☐	☐	Ear pain
☐	☐	urination Discolored	☐	☐	Ear noises
☐	☐	urine Cardio-Vascular Respiratory	☐	☐	Hearing loss
☐	☐	Chest pain	☐	☐	Ear discharge
☐	☐	Pain over heart	☐	☐	Nose pain
☐	☐	Difficulty breathing	☐	☐	Nose bleeding
☐	☐	Persistent cough	☐	☐	Nose pain
☐	☐	Coughing phlegm	☐	☐	Nose pain
☐	☐	Coughing blood	☐	☐	Sore gums

Musculo-Skeletal System

Please check all that you are currently experiencing and a check under "P" column for past issues.

✓	P		
☐	☐	Dental problems	
☐	☐	Sore mouth sore throat	

✓	P		
☐	☐	Hoarseness	
☐	☐	Difficulty with speech	

On the diagram place Xs on your current areas of pain