



New Client Questionnaire

Your Details

First Name

Belinda

Surname

Perisic

Address

392 Shannon Avenue

Suburb

Newtown

State

- ☒ VIC
- ☐ NSW
- ☐ SA
- ☐ QLD
- ☐ WA
- ☐ TAS
- ☐ ACT
- ☐ NT

Email Address

belindaperisic@hotmail.com

Phone Number

0434532044

Age

42

Occupation

General Manager

List your current health concerns in order of importance

Health Concerns
MS
Asthma
Thyroid

Outline some more information about the reason for your visit

For example: aggravating/alleviating factors; things that make better/worse / any treatments you've had in the past

I need to lose weight but with my MS, am currently finding it difficult to do more exercise than I am already doing, which is at least 30 minutes at least five times a week. I also eat far too much chocolate!

Family History**Family History**

Family Member	Illness	Age
My Dad was recently diagnosed with Type 2 Diabetes	Type 2 Diabetes	74
`1		

Personal Health History

Medical Diagnosis / Illness / Operations

Illness / Operation	Year Occurred
MS	2016
Asthma	a long time ago!
Thyroid	2013

Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason
Aubagio (teriflunomide)	14mg	once daily	August 2016	MS
Symicort Turboinhaler	200g	two puffs, twice daily		Asthma
Eutroxsig	125mg	once daily	2013	Thyroid
Akamin	50mg	twice daily	May 2022	Acne
Diance		once daily	2015	Contraceptive pill

Supplements

List all supplements you're currently taking including vitamins, herbs, minerals.

Supplement	Dose	Frequency	Start Date	Reason
Vitamin D	1000iu	once daily	2016	MS
Iron Plus		once daily	2022	low iron
Vitamin B12	100mg	once daily	2022	low B12

Lifestyle

Stress - List the major stress factors in your life

Sleep - Please tick all that are applicable to you

- | | |
|--|---|
| <input type="checkbox"/> Difficulty falling asleep | <input checked="" type="checkbox"/> Teeth Grinding |
| <input type="checkbox"/> Snoring | <input checked="" type="checkbox"/> Waking during the night |
| <input checked="" type="checkbox"/> Waking unrefreshed | <input type="checkbox"/> Insomnia |

Sleep - What time do you normally wake-up and go to bed?

9.30-10.30pm bedtime and up between 6am and 7am

Exercise - Do you currently participate in any regular activity or program?

☒ Yes ☐ No

Exercise Details

Exercise/Activity	Times per wk	Intensity
Walking	five to six times per week	varies, outside and inside on treadmill

Do you currently smoke tobacco?

☐ Yes ☒ No

Digestive Health

Do you experience digestive difficulties?

- | | |
|--|---------------------------------|
| <input checked="" type="checkbox"/> Bloating | <input type="checkbox"/> Wind |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> None | |

How often do you have a bowel movement?

up to three times a day, mostly in the morning

Do you strain to have a bowel movement?☐ Yes ☒ No**How would you describe your bowel motions?**

- ☒ Formed
☐ Loose
☐ Constipated
☐ Mixed: loose and constipated

Do you take laxatives?☐ Yes ☒ No

Intolerances / Allergies

List any food or environmental allergies you experience

Food/Environmental Allergies	Reaction
Hayfever	Runny nose, itchy eyes, itchy throat
FODMAPS - garlic and onion	bloating, upset tummy
Wheat?	bloating, upset tummy

Diet

Do you follow a special diet?

e.g. gluten free, vegetarian etc

No

How much water do you drink daily?

2L on most days

Do you consume coffee?☐ Yes ☒ No**Do you consume tea?**☐ Yes ☒ No

Do you add sugar to tea or coffee?

Do you consume alcohol?

☐ Yes ☒ No

List any other drinks you consume

Bickfords Lemon, Lime, Bitters cordial of an afternoon/evening, hot chocolate in the morning, and water during the day.

Average Daily Diet

Please list quantity where known e.g. 2 slices bread with 2 eggs

Breakfast	Lactose free greek yoghurt with gold kiwi fruit or strawberries and homemade granola (hazelnuts, pepitas, sunflower seeds, brown sugar, cinn
Snack	Hot chocolate
Lunch	Varies, chicken caesar salad, left over pasta or stirfry, halloumi wrap, scrambled eggs on toast with avocado and fetta
Snack	Chocolate
Dinner	Varies - fish (salmon/orange roughy) and homemade chips, roast chicken wraps with avocado, fajitas, spaghetti
Supper	Chocolate

Do you have any foods you dislike / avoid?

I don't like anything spicy!

On a scale of 1 - 10, how confident are you preparing your own meals at home?

1 = not confident; 10 = very confident

5 - I don't really have a knack at putting meals together, but can follow a recipe!

FOR FEMALE PATIENTS

Are you still menstruating?

☒ Yes ☐ No

How many days do you have your period for?

5

How heavy is the flow?

- ☐ Light
☒ Average
☐ Heavy
☐ Other

If "Other", please specify

State any premenstrual symptoms you suffer from

If you are on contraception, please list type

Diane

OTHER

How did you find out about my practice?

- ☒ Referral from friend or other
☐ Internet Search
☐ Social Media
☐ Other

If "Other", please specify

Would you like to receive my monthly email newsletter (Health tips, research and recipes)

☒ Yes ☐ No

Client

I hereby agree and understand that the treatment/advice given will include one or more of the following; dietary prescription, lifestyle prescription, nutritional supplements and screening tests, which I knowingly and willingly consent to undergo of my own free will. At any time I may reject any treatment or advice with prejudice from the practitioner. I understand that nutritional supplements are prescribed in a therapeutic fashion and if circumstances change (Eg. pregnancy, cessation/commencement of pharmaceutical drugs etc) from what was presented to the practitioner, I will notify the practitioner immediately, so treatment/advice can alter accordingly if required. I recognise that Mel Bald will rely upon the signing of this document in accepting me as a patient.



X




Belinda Perisic

June 4, 2022

Audit Trail

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