New Client Questionnaire

Your Details

First Name

Jordan

Surname

Stewart

Address

3 Darriwell drive

Suburb

Bannockburn

State

- (●) VIC
- ( ) NSW
- ( ) SA
- ( ) QLD
- ( ) WA
- ( ) TAS
- ( ) ACT
- ( ) NT

Email Address

Jordan892.js@gmail.com

Phone Number

0414 464 936

Age

28

Occupation

Carpenter

List your current health concerns in order of importance

Health Concerns
Weight
Feeling flat

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

Have lost weight in the past and changed my eating habbits easily but have struggled to do so for the recent few years.

Family History

Family History

Family Member	Illness	Age
Grandad	Bow Cancer	60
Mum	Kidney stones an gall bladder removed	50

Personal Health History

Medical Diagnosis / Illness / Operations

Illness / Operation	Year Occurred
Kidney stones	2016

Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason

Supplements

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

Supplement	Dose	Frequency	Start Date	Reason

Lifestyle

Stress - List the major stress factors in your life

I stress about money and not having structure in every aspect.

Sleep - Please tick all that are applicable to you

- [x] Difficulty falling asleep
- [ ] Teeth Grinding

- [x] Snoring
- [x] Waking unrefreshed
- [x] Waking during the night
- [ ] Insomnia

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

I normally wake up at 6.00 to 6.30am and im in bed most nights by 9.30pm but could fall asleep anywhere between 11 an midnight

Exercise - Do you currently participate in any regular activity or program? ○ Yes ◉ No

Exercise Details

Exercise/Activity	Times per wk	Intensity

Do you currently smoke tobacco? ○ Yes ◉ No

Digestive Health

Do you experience digestive difficulties?

- [x] Bloating
- [ ] Cramping
- [ ] None
- [ ] Wind
- [ ] Reflux

How often do you have a bowel movement?

Once to twice a day

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
Pasta	Get bloated

Diet

Do you follow a special diet?
e.g. gluten free, vegetarian etc

No

How much water do you drink daily?

1 to 2 Litres

Do you consume coffee? ◉ Yes ○ No

If so, how many cups per day?

2 to 3

Do you consume tea? ○ Yes ◉ No

Do you add sugar to tea or coffee?

Yes 2 sugars

Do you consume alcohol? ◉ Yes ○ No

If so, how much, how often?

Twice a week

List any other drinks you consume

Energy drinks

Average Daily Diet

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

Breakfast	Egg and bacon toastie or a muffin
Snack	Packet of shapes and fruit
Lunch	Left overs or take away
Snack	
Dinner	Spaghetti bolognese, Vietnamese rolls, pizza, chicken schnitzels rolls, baked chicken with vegetables and wedges, homemade chicken parmis
Supper	

Do you have any foods you dislike / avoid?

Yoghurt, ricotta, olives and really spicy food, goats cheese,

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

1 = not confident; 10 = very confident

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FOR FEMALE PATIENTS

Are you still menstruating? ◯ Yes ◉ No

How many days do you have your period for?

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

OTHER

How did you find out about my practice?

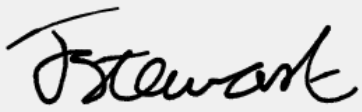
- ◯ Referral from friend or other
- ◉ Internet Search
- ◯ Social Media
- ◯ Other

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

Jordan Stewart **May 3, 2022**

Audit Trail

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