



New Client Questionnaire

Your Details

First Name

Veronica

Surname

Jenkins

Address

15/54 Percy St

Suburb

Newtown

State

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

Email Address

vjenkins11@hotmail.com

Phone Number

0409416117

Age

46

Occupation

Government Administration

List your current health concerns in order of importance

Health Concerns
Weight
Inflammation
Lack of energy/fitness levels
Stress levels
Interrupted sleep
Allergies (hayfever, dust etc)

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'd like some advice/tools on how to lose weight (fat).

Family History**Family History**

Family Member	Illness	Age

Personal Health History

Medical Diagnosis / Illness / Operations

Illness / Operation	Year Occurred

Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason
Hayfever tablets	1	Daily		Hayfever

Supplements

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

Supplement	Dose	Frequency	Start Date	Reason
NeuroCalm		3 daily	25/3/22	Stress
AdrenoTone		twice daily	25/3/22	Adrenals
Vitamin D		once daily	25/3/22	
Magnesium		nightly	25/3/22	Sleep/muscles
Tumeric		once daily		Inflammation
Herbal tincture with Chamomile, Californian Poppy, Echinacea and Meadowsweet	15ml	once daily	21/3/33	Digestion and stress

Lifestyle

Stress - List the major stress factors in your life

Hectic job, weight

Sleep - Please tick all that are applicable to you

- | | |
|--------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Teeth Grinding |
| <input checked="" 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?

5am wake up, go to bed at 8:30pm

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

☒ Yes ☐ No

Exercise Details

Exercise/Activity	Times per wk	Intensity
CrossFit	3	Medium to High
Yoga	1	Low
Walk	2-3	Low

Do you currently smoke tobacco?

☐ Yes ☒ No

Digestive Health

Do you experience digestive difficulties?

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

How often do you have a bowel movement?

2-3 per 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

Diet

Do you follow a special diet?

e.g. gluten free, vegetarian etc

No

How much water do you drink daily?

2-3 litres

Do you consume coffee?

☒ Yes ☐ No

If so, how many cups per day?

2

Do you consume tea?

☒ Yes ☐ No

If yes, how many cups per day?

0-1

Do you add sugar to tea or coffee?

No

Do you consume alcohol?

☒ Yes ☐ No

If so, how much, how often?

4-6 occasionally

List any other drinks you consume

soda water, kombucha, peppermint tea

Average Daily Diet

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

Breakfast	Smoothie
Snack	protein bar, nuts
Lunch	poke bowl
Snack	dark chocolate, popcorn
Dinner	lamb chops, veggies
Supper	

Do you have any foods you dislike / avoid?

Onions, chillies, eggplant

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

1 = not confident; 10 = very confident

6

FOR FEMALE PATIENTS

Are you still menstruating?

☒ Yes ☐ No

How many days do you have your period for?

4-5

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

Femme-Tab ED 30/150

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






Veronica Jenkins

March 29, 2022

Audit Trail

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