



New Client Questionnaire

Your Details

First Name

Amelia

Surname

Ford

Address

39 leawarra way

Suburb

Clifton springs

State

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

Email Address

amford412@gmail.com

Phone Number

0418977255

Age

23

Occupation

Optical dispenser

List your current health concerns in order of importance

Health Concerns
Hypothyroidism- not diagnosed but have many symptoms
Type 1 diabetes

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 was told I could start medication when I got worse however I feel sick all the time and want to understand how I can better manage and prevent thyroid disease. I've been cutting down drastically on sugar (artificial kind) and that definitely helps! My gland in my throat would usually be swollen and sore

Family History**Family History**

Family Member	Illness	Age
Nana	Thyroid diseases	83

Personal Health History

Medical Diagnosis / Illness / Operations

Illness / Operation	Year Occurred
Type 1 diabetes	2005
General anxiety and mild depression	2021

Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason
Insulin novorapid	60u a day	Pump- constant	2005	Diabetes
Fluoxetine	20mg	Once daily	2021	Mental health

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

Work

Sleep - Please tick all that are applicable to you

- ☐ Difficulty falling asleep
☐ Snoring
☒ Waking unrefreshed

- ☒ Teeth Grinding
☐ Waking during the night
☐ Insomnia

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

Sleep around 10-10:30. Wake up is 6am on work days, 7:30-9 on non work days

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?

- ☒ Bloating ☒ Wind
☐ Cramping ☐ Reflux
☐ None

How often do you have a bowel movement?

Usually every day, sometimes every other

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

Diet

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

No

How much water do you drink daily?

Around 1 litre

Do you consume coffee?

☒ Yes ☐ No

If so, how many cups per day?

1-2

Do you consume tea?

☐ Yes ☒ No

Do you add sugar to tea or coffee?

No

Do you consume alcohol?

☒ Yes ☐ No

If so, how much, how often?

2 times week maximum, 8 drinks max

List any other drinks you consume

Average Daily Diet

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

Breakfast	Two slices of toast usually rye sourdough, peanut butter or Vegemite and oat milk coffee
Snack	Piece of fruit or a pastrie
Lunch	Usually a sourdough baguettes with ham, cheese, egg, mayo, pickle and lettuce
Snack	
Dinner	Some form of carb eg. rice potato pasta. Could be bolognese, curry, stir fry
Supper	

Do you have any foods you dislike / avoid?

Dairy

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

1 = not confident; 10 = very confident

10

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

Fatigue

If you are on contraception, please list type

Yes levlen

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

Amelia Ford**May 12, 2022**

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