



# New Client Questionnaire

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## Your Details

**First Name**

Lucy

**Surname**

Chambers

**Address**

12a Cheltenham Rd

**Suburb**

Newcomb

**State**

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

**Email Address**

salwatson75@gmail.com

**Phone Number**

0430863300

**Age**

12

**Occupation**

Student

**List your current health concerns in order of importance**

Health Concerns
Understanding how good works in our body - satisfies appetite
What are good food choices
Use of scales / body image
Possible lactose intolerance

**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

Dietary advice

**Family History****Family History**

Family Member	Illness	Age
Mum	Lactose and gluten intolerances	46

## Personal Health History

### Medical Diagnosis / Illness / Operations

Illness / Operation	Year Occurred
Constipation	Since 2 yrs old - was treated with movicol when younger: happens every couple of months

### 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

Anxiety - school related /non-attendance  
Body image

### 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?**

Wake up 8, sleep 1030/11

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

☐ Yes ☒ No

**Exercise Details**

Exercise/Activity	Times per wk	Intensity
Walk	3	
Exercises	6	

**Do you currently smoke tobacco?**

☐ Yes ☒ No

## Digestive Health

**Do you experience digestive difficulties?**

- ☒ Bloating  
☒ Cramping  
☐ None

- ☒ Wind  
☐ Reflux

**How often do you have a bowel movement?**

A bit haphazard - currently doing a bowel diary after seeing physio last week for pelvic floor / incontinence when sneeze

**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
Possibly lactose	Stomach ache / diarrhoea

**Diet****Do you follow a special diet?**

e.g. gluten free, vegetarian etc

No

**How much water do you drink daily?**

2l

**Do you consume coffee?**

☐ Yes ☒ No

**Do you consume tea?**

☒ Yes ☐ No

*If yes, how many cups per day?*

1

**Do you add sugar to tea or coffee?**

No

Do you consume alcohol?

☐ Yes ☒ No

List any other drinks you consume

### Average Daily Diet

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

Breakfast	Not usually
Snack	Snack cupboard surfing -
Lunch	
Snack	
Dinner	Spag, salad bowls, schnitzel, tacos,
Supper	

Do you have any foods you dislike / avoid?

Seafood

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

1 = not confident; 10 = very confident

8

## FOR FEMALE PATIENTS

Are you still menstruating?

☒ Yes ☐ No

How many days do you have your period for?

7 very heavy

**How heavy is the flow?**

- ☐ Light  
☐ Average  
☒ Heavy  
☐ Other

*If "Other", please specify*

**State any premenstrual symptoms you suffer from**

Cramping

**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

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**Sally Watson****May 4, 2022**



## Audit Trail

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