



New Client Questionnaire

Your Details

First Name

Kelly

Surname

Inglis

Address

302 Glen Avon Drive

Suburb

Bannockburn

State

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

Email Address

kelly@theskinhub.com.au

Phone Number

0425805958

Age

42

Occupation

Business owner and cosmetic tattooist

List your current health concerns in order of importance

Health Concerns
overweight
lethargic
psoriasis
moody/ bad relationship with food

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 would like to learn more about what food i should be eating for my age and health. portion size, the right foods. the information out there is so confusing.

Family History**Family History**

Family Member	Illness	Age
aunt and uncle	diabetes	50's

Personal Health History

Medical Diagnosis / Illness / Operations

Illness / Operation	Year Occurred
psoriasis	for 38 years, since i was five years old
cervical operation	2019
gestational diabetes	2011 with first baby but not with second or third babies.

Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason
Enstilar foam	spray form	daily	2019	psoriasis

Supplements

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

Supplement	Dose	Frequency	Start Date	Reason
relax stress relief	2 to 3 capsules	once a week	2019	stress

Lifestyle

Stress - List the major stress factors in your life

work

Sleep - Please tick all that are applicable to you

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

go to sleep between 10 and 12pm - wake up between 6.30am and 8am if a day off

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?

- | | |
|--|--|
| <input checked="" type="checkbox"/> Bloating | <input 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 to 3 times 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
hot chocolate drink	burning on skin where psoriasis is
pancakes or waffles, that kind of thing	makes me feel nauseous

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

Do you consume tea?

☒ Yes ☐ No

If yes, how many cups per day?

2

Do you add sugar to tea or coffee?

yes 1 teaspoon

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	varies, sometimes just a banana, mostly 2 x toast, i prefer dark rye or sourdough with butter, cream cheese and marmalade
Snack	
Lunch	leftovers like lasagne or tuna and salad if at work, subway, sushi rolls,
Snack	2 or 3 small chocolates
Dinner	usually meat and veg, pizza, have been trying to eat more fish and salads
Supper	chips, chocolate, snack things,

Do you have any foods you dislike / avoid?

oysters and muscles

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

1 = not confident; 10 = very confident

7

FOR FEMALE PATIENTS

Are you still menstruating?

☒ Yes ☐ No

How many days do you have your period for?

4 to 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

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




Kelly Inglis

February 2, 2022

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