



# New Client Questionnaire

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## Your Details

**First Name**

Kirsty

**Surname**

Dryden

**Address**

4 Greenbank Drive

**Suburb**

Mooroolbark

**State**

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

**Email Address**

kirstydryden71@gmail.com

**Phone Number**

0427142882

**Age**

50

**Occupation**

Maternal child health nurse

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

Health Concerns
Obesity
IBS
Pre 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

Weight loss support, improved gut health

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

Family Member	Illness	Age
Brother	IDDM	56
Mother	Diabetes. Diet controlled	75
Father... deceased	Cardiac	74

## Personal Health History

### Medical Diagnosis / Illness / Operations

Illness / Operation	Year Occurred
Depression	2002
Osteoarthritis right knee	2021

### Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason
Lexapro	20mg	Daily	Years ago	

### 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

Children and occupation

### 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?**

Bed 10:30pm, up 7am

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

☒ Yes ☐ No

#### Exercise Details

Exercise/Activity	Times per wk	Intensity
Water walking	2	

**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?**

Daily

**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
Oyster	Vomit
Salmon	Vomit
Dates	Mouth irritation
Walnuts	Mouth Irritation

## Diet

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

No

How much water do you drink daily?

500-1000mls

Do you consume coffee?

☒ Yes ☐ No

If so, how many cups per day?

1

Do you consume tea?

☒ Yes ☐ No

If yes, how many cups per day?

2

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	Yoghurt & fruit
Snack	Soy latte
Lunch	Salad and protein
Snack	Banana and a boiled egg
Dinner	Veg or salad, potato or pasta or rice and a protein like chicken or steak or bolognese
Supper	Tea

**Do you have any foods you dislike / avoid?**

Sweet potato, peas, salmon, tuna, kangaroo, oysters, dates, walnuts

**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?

4

**How heavy is the flow?**

- ☒ Light  
☐ Average  
☐ Heavy  
☐ Other

*If "Other", please specify*

**State any premenstrual symptoms you suffer from**

Mood swing, bloating

**If you are on contraception, please list type**

Mirena

**OTHER****How did you find out about my practice?**

- ☐ Referral from friend or other  
☐ Internet Search  
☐ Social Media  
☒ Other

*If "Other", please specify*

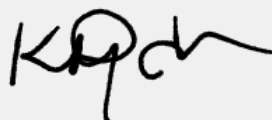
Lifestyle program

**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.



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X

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Kirsty Dryden




December 7, 2021



## Audit Trail

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