New Client Questionnaire

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

- [x] Difficulty falling asleep
- [x] Snoring
- [x] Waking unrefreshed
- [x] 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?

- [x] Bloating
- [ ] Cramping
- [ ] None
- [x] Wind
- [ ] Reflux

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.

X

Kirsty Dryden **December 7, 2021**

Audit Trail

Title	New Client Questionnaire
Document ID	61af127e3980330fdccc93c4
Status	Completed

Document History

Status	Timestamp	Notes
Viewed	12/07/2021 8:50:07 PM (AEDT)	Form viewed by Kirsty Dryden (kirstydryden71@gmail.com) IP Address: 101.186.13.103
Signed	12/07/2021 9:01:36 PM (AEDT)	Form signed by Kirsty Dryden IP Address: 101.186.13.103
Completed	12/07/2021 9:01:36 PM (AEDT)	Completed by Kirsty Dryden (kirstydryden71@gmail.com) IP Address: 101.186.13.103