New Client Questionnaire

Your Details

First Name

Nikkole

Surname

Callard

Address

35 Oceania drive

Suburb

Curlewis

State

- (●) VIC
- ( ) NSW
- ( ) SA
- ( ) QLD
- ( ) WA
- ( ) TAS
- ( ) ACT
- ( ) NT

Email Address

ncallard2017@outlook.com

Phone Number

0408868462

Age

39

Occupation

Childcare educator

List your current health concerns in order of importance

Health Concerns
Weight management
Bloating
BMI

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

Bloating. Want to lower my BMI and loose 10 kg

Family History

Family History

Family Member	Illness	Age

Personal Health History

Medical Diagnosis / Illness / Operations

Illness / Operation	Year Occurred

Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason
Duramine	1	Daily	22/2/22	Weight lose

Supplements

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

Supplement	Dose	Frequency	Start Date	Reason
Fish oil	2	Daily		
Magnesium	1	Daily		
Probiotic	2	Daily		
Glucosamine	1	Daily		

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?

Depends on work requirements. Usually wake early and go to bed early

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?

- [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

Diet

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

No

How much water do you drink daily?

2-3 litres

Do you consume coffee? ◉ Yes ○ No

If so, how many cups per day?

3

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?

Weekends up to 8 drinks per night

List any other drinks you consume

Average Daily Diet

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

Breakfast	Oats
Snack	Smoothie
Lunch	Wrap
Snack	Fruit
Dinner	Protein and salad or vegetables
Supper	

Do you have any foods you dislike / avoid?

Peas

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?

2-3

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?

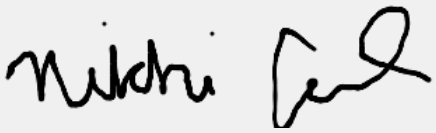
- ◯ Referral from friend or other
- ◉ Internet Search
- ◯ Social Media
- ◯ Other

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.



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Nikkole Callard **February 24, 2022**

Audit Trail

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