



New Client Questionnaire

Your Details

First Name

Emily

Surname

Howard

Address

58 Tova Avenue

Suburb

Bell post hill

State

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

Email Address

Emily-howard@hotmail.com

Phone Number

0407906577

Age

26

Occupation

Student/broker

List your current health concerns in order of importance

Health Concerns
Dieting for training
Weight loss
Build muscle

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

Na

Family History**Family History**

Family Member	Illness	Age
Mum	Diabetes	56
Grandmother	Diabetes	80
Dad	Diabetes	59

Personal Health History

Medical Diagnosis / Illness / Operations

Illness / Operation	Year Occurred
Glandular fever	2014

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
Creatine	1 scoop	Daily	Last 6 months	

Lifestyle

Stress - List the major stress factors in your life

Sleep - Please tick all that are applicable to you

☐

Difficulty falling asleep

☐

Teeth Grinding

- ☐ Snoring ☐ Waking during the night
☒ Waking unrefreshed ☐ Insomnia

Sleep - What time do you normally wake-up and go to bed?

Bed - 10pm. Wake up 6am

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

☒ Yes ☐ No

Exercise Details

Exercise/Activity	Times per wk	Intensity
Weights and cardio	6-7	Mid-high

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?

2 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?

1-3 litres a day

Do you consume coffee?

☒ Yes ☐ No

If so, how many cups per day?

2 a week

Do you consume tea?

☐ Yes ☒ No

Do you add sugar to tea or coffee?

Do you consume alcohol?

☒ Yes ☐ No

If so, how much, how often?

1 drink a month

List any other drinks you consume

Average Daily Diet

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

Breakfast	Protein shake and banana, creatine
Snack	Protein muesli bar
Lunch	Granola, Greek yogurt and banana and berries
Snack	Bar again
Dinner	Chicken rice, veggies
Supper	Popcorn, dry biscuits

Do you have any foods you dislike / avoid?

Salmon

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?

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





Emily Howard

March 1, 2022

Audit Trail

Title	New Client Questionnaire
Document ID	621d6e57526e367cd3ebbf1b
Status	Completed

Document History

Status	Timestamp	Notes
 Viewed	03/01/2022 11:53:37 AM (AEDT)	Form viewed by Emily Howard (emily-howard@hotmail.com) IP Address: 40.94.31.40
 Viewed	03/01/2022 11:53:44 AM (AEDT)	Form viewed by Emily Howard (emily-howard@hotmail.com) IP Address: 1.136.18.43
 Signed	03/01/2022 12:05:37 PM (AEDT)	Form signed by Emily Howard IP Address: 1.136.18.43
 Completed	03/01/2022 12:05:37 PM (AEDT)	Completed by Emily Howard (emily-howard@hotmail.com) IP Address: 1.136.18.43