



# New Client Questionnaire

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## Your Details

**First Name**

Bella

**Surname**

Gard

**Address**

12 Daisy Street

**Suburb**

Newtown

**State**

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

**Email Address**

bellagard023@gmail.com

**Phone Number**

0456862333

**Age**

19

**Occupation**

Student

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

Health Concerns
Extreme bloating
Constipation
Occasional diarrhoea

**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

Discomfort in clothing, tight abdominal feeling and concerned about lack of bowel movement. This is all causing me low self esteem and mood. This bloating is making me have a lack of interest in eating food.

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

Family Member	Illness	Age
Kelly Gard / Mother	Bronchiectasis	54

## Personal Health History

### Medical Diagnosis / Illness / Operations

Illness / Operation	Year Occurred
Saw Robert Claridge for constipation	2017

### Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason
Mini pill		Daily	20/11/20	Skin and Contraception
Isotretinoin (Roaccutane)	40mg	Daily	2019	Cystic Acne

### Supplements

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

Supplement	Dose	Frequency	Start Date	Reason
JS Health Detox and Debloat	2	Daily	27/09/21	For bloating

## Lifestyle

### Stress - List the major stress factors in your life

Do suffer from occasional anxiety. Struggled during 2020 VCE Year in Covid and mental health not great. Recently relationship break-up with boyfriend of 2 years.

### Sleep - Please tick all that are applicable to you

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Teeth Grinding          |
| <input type="checkbox"/> Snoring                              | <input type="checkbox"/> Waking during the night |
| <input type="checkbox"/> Waking unrefreshed                   | <input type="checkbox"/> Insomnia                |

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

Go to bed 11pm; Wake up at 9am

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

☐ Yes ☒ No

### Exercise Details

Exercise/Activity	Times per wk	Intensity
Walking	4	30 mins - 1 hour

### Do you currently smoke tobacco?

☐ Yes ☒ No

## Digestive Health

### Do you experience digestive difficulties?

- |  |                                 |
|--|---------------------------------|
| <input checked="" type="checkbox"/> Bloating | <input type="checkbox"/> Wind   |
| <input checked="" type="checkbox"/> Cramping | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> None                |                                 |

**How often do you have a bowel movement?**

1-2 times a week

**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?**

2.5 litres

**Do you consume coffee?**☒ Yes ☐ No*If so, how many cups per day?*

1 cup Almond Latte per day or a powdered chai latte

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?*

Twice a week

List any other drinks you consume

Diet Coke

### Average Daily Diet

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

Breakfast	Don't have breakfast
Snack	Fruit (Mango / Blueberries / Strawberries) Chai Latte
Lunch	Salad or Acai bowl or rice paper rolls
Snack	Vitawheats and hummus or rice cakes
Dinner	Meat (lamb/chicken/pork) and 3-4 Veggies roasted or steamed Salmon baked or Fish and Veggies (as above)
Supper	

Do you have any foods you dislike / avoid?

Nuts, normal milk (only have almond), pasta, bread other than sourdough

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?

Very irregular, didn't get my period for 10 months (20/11/20 - 17/8/21) \*Note: Started mini pill early Nov 2020

How heavy is the flow?

- ☒ Light  
☐ Average  
☐ Heavy  
☐ Other

*If "Other", please specify*

State any premenstrual symptoms you suffer from

No

If you are on contraception, please list type

Mini Pill

## 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

Bella Gard







October 6, 2021



## Audit Trail

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