New Client Questionnaire

Your Details

First Name

Julie

Surname

Duffield

Address

107 Kensington Rd

Suburb

Leopold

State

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

Email Address

julie.duffield@bigpond.com

Phone Number

0422698337

Age

60

Occupation

Retiree

List your current health concerns in order of importance

Health Concerns
High cholesterol
Low bone density
Excess weight

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

My cholesterol levels have increased on two occasions over past 2-3 yrs. It seems to yo yo because I don't stick to a strict low fat diet. I know that I need a good calcium intake but realise dairy is high cholesterol and weight gaining. My weight has increased more than I like. I'm really health food conscious but something's not working for me. I'm frustrated!

Family History

Family History

Family Member	Illness	Age
Mother	Multiple sclerosis	79

Personal Health History

Medical Diagnosis / Illness / Operations

Illness / Operation	Year Occurred
Skin cancer - Bcc	2021, 1992
Not an illness but went through menopause at age 45	

Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason
Nil				

Supplements

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

Supplement	Dose	Frequency	Start Date	Reason
Vitamin D	1	Daily	4 yr ago	
Magnesium	1	5 days per week	Intermittently past 2 yrs	

Lifestyle

Stress - List the major stress factors in your life

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?

6am - 10pm

Exercise - Do you currently participate in any regular activity or program? ◉ Yes ○ No

Exercise Details

Exercise/Activity	Times per wk	Intensity
Walk	4	40 min
Gardening	5	90min

Do you currently smoke tobacco? ○ Yes ◉ No

Digestive Health

Do you experience digestive difficulties?

- ☑ Bloating
- ☐ Cramping
- ☐ None
- ☐ Wind
- ☐ Reflux

How often do you have a bowel movement?

1-2 times per day

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?

1.5 L

Do you consume coffee? ◉ Yes ○ No

If so, how many cups per day?

2

Do you consume tea? ◉ Yes ○ No

If yes, how many cups per day?

3

Do you add sugar to tea or coffee?

No

Do you consume alcohol? ◉ Yes ○ No

If so, how much, how often?

4 standard per mth

List any other drinks you consume

Average Daily Diet

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

Breakfast	1 bowl wholegrain ceral or porridge with low fat milk.Usually with some bannana or berries. OR one egg on sourdough with avo .
Snack	Coffee, sometimes with a homemade sweet
Lunch	Leftovers, egg on toast, tuna and salad, tomatoes on toast
Snack	Nuts, fruit , cheese and crackers.
Dinner	Chicken, pork, or beef and veg. We grow a lot of veggies and they usually determine our meals. Fish once or twice per week. Fruit and yoghur
Supper	Cup of tea and something sweet. 2 squares of dk choc,or homemade treat,or nuts or cracker biscuits.

Do you have any foods you dislike / avoid?

Seafood other than fish

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?

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

Julie Duffield **February 2, 2022**

Audit Trail

Title	New Client Questionnaire
Document ID	61fa191e3980330bc0bc554e
Status	Completed

Document History

Status	Timestamp	Notes
Viewed	02/02/2022 5:21:37 PM (AEDT)	Form viewed by Julie Duffied (julie.duffield@bigpond.com) IP Address: 120.158.149.166
Signed	02/02/2022 6:22:12 PM (AEDT)	Form signed by Julie Duffield IP Address: 120.158.149.166
Completed	02/02/2022 6:22:12 PM (AEDT)	Completed by Julie Duffied (julie.duffield@bigpond.com) IP Address: 120.158.149.166