



New Client Questionnaire

Your Details

First Name

Olivia

Surname

Cerepinko

Address

7 Ralph court

Suburb

Bell park

State

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

Email Address

mazzcerekpoko@yahoo.com.au

Phone Number

0405 840 649

Age

15

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

Health Concerns
Lose fat
form a better relationship with good
Stop binging
Get fitter
Balance

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

I'd just like some professional guidance to what I can achieve and to do it in the right healthy way

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

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

Body image
School
Friends
Work

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?

10:30 6:30

Exercise - Do you currently participate in any regular activity or program?☒ Yes ☐ No**Exercise Details**

Exercise/Activity	Times per wk	Intensity
Run	2/3 times a week	5km
Weights	3-4 times a week	45 minute
Soccer starts back this week	3 times a week	1hr 45 minute sessions

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?

Very very often

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
Artificial colours and flavours	Rash and sore stomach

Diet

Do you follow a special diet?

e.g. gluten free, vegetarian etc

Used to follow Keto

How much water do you drink daily?

4/5 cups

Do you consume coffee?

☐ Yes ☒ No

Do you consume tea?

☐ Yes ☒ No

Do you add sugar to tea or coffee?

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	2eggs with veggies and salami/ham
Snack	Fruit
Lunch	Leftovers from dinner
Snack	Sometimes fruit if I get hungry
Dinner	Differnt every day but some sort of meat and some sort of veg
Supper	

Do you have any foods you dislike / avoid?

Pasta

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?

7

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








Olivia cerepinko

January 27, 2022

Audit Trail

Title	New Client Questionnaire
Document ID	61f1202439803300c877fc25
Status	Completed

Document History

Status	Timestamp	Notes
 Sent	01/26/2022 9:19:16 PM (AEDT)	Form sent for signature/consent to Olivia Cerepinko (mazzcerekpinko@yahoo.com.au) IP Address: 203.221.108.231
 Viewed	01/27/2022 5:38:36 AM (AEDT)	Form viewed by Olivia Cerepinko (mazzcerekpinko@yahoo.com.au) IP Address: 203.221.17.147
 Viewed	01/27/2022 8:00:44 AM (AEDT)	Form viewed by Olivia Cerepinko (mazzcerekpinko@yahoo.com.au) IP Address: 203.221.17.147
 Signed	01/27/2022 8:30:48 AM (AEDT)	Form signed by Olivia cerepinko IP Address: 203.221.17.147
 Completed	01/27/2022 8:30:48 AM (AEDT)	Completed by Olivia Cerepinko (mazzcerekpinko@yahoo.com.au) IP Address: 203.221.17.147