New Client Questionnaire

Your Details

First Name

Joanna

Surname

Stevens

Address

28 St Leger Close

Suburb

Newington

State

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

Email Address

jstevens@premierstrategy.com.au

Phone Number

0408288740

Age

46

Occupation

CEO

List your current health concerns in order of importance

Health Concerns
Hashimoto's - thyroid condition
Menopause symptoms
Stress & anxiety
Weight loss
High cholesterol

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

Improve my diet to make me feel better, reduce thyroid medication, avoid high cholesterol medication

Family History

Family History

Family Member	Illness	Age
Mother	breast cancer	60
Father	heart disease - died of a heart attack	62
Melanoma	Grandmother	

Personal Health History

Medical Diagnosis / Illness / Operations

Illness / Operation	Year Occurred
Cancer - 3 x surgeries (metastatic melanoma)	2012
Full auxiliary clearance	2021
Hashimoto's diseases	2020

Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason
thyroxine	150 mg	daily	2020	Hashimoto's
sertraline	25mg	daily	2018	Anxiety, PMT

Supplements

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

Supplement	Dose	Frequency	Start Date	Reason
Herbal mix	8ml	daily	2015	

Lifestyle

Stress - List the major stress factors in your life

work, cancer reoccurrence

Sleep - Please tick all that are applicable to you

- [ ] Difficulty falling asleep
- [ ] Snoring
- [ ] Waking unrefreshed
- [ ] Teeth Grinding
- [x] Waking during the night
- [ ] Insomnia

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

9:30am - 5:45am

Exercise - Do you currently participate in any regular activity or program? (●) Yes ( ) No

Exercise Details

Exercise/Activity	Times per wk	Intensity
Running	3 - 4	med - hard
walking	daily	med
Pilates	3	med
exercises	2	med

Do you currently smoke tobacco? ( ) Yes (●) No

Digestive Health

Do you experience digestive difficulties?

- [x] Bloating
- [ ] Cramping
- [ ] None
- [ ] 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
No	

Diet

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

No

How much water do you drink daily?

3 glasses

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?

2

Do you add sugar to tea or coffee?

no

Do you consume alcohol? ◉ Yes ○ No

If so, how much, how often?

3 nights, 2 glasses.

List any other drinks you consume

Average Daily Diet

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

Breakfast	yoghurt and museli
Snack	
Lunch	salad
Snack	chocolate, apple
Dinner	pasta, salmon and veggies
Supper	

Do you have any foods you dislike / avoid?

No

On a scale of 1 - 10, how confident are you preparing your own meals at home?

1 = not confident; 10 = very confident

5 - confident, but busy

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

bloating, cranky

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

Joanna Stevens **January 25, 2022**

Audit Trail

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