



New Client Questionnaire

Your Details

First Name

Sachi

Surname

Bridgeford

Address

118 sunset strip

Suburb

Jan juc

State

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

Email Address

sachib05@icloud.com

Phone Number

0437067569

Age

16

Occupation

Student

List your current health concerns in order of importance

Health Concerns
Not getting enough vege protein
Low iron
Low energy

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

Get a vegetarian meal plan

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
Iron		Daily	2020	Low iron levels

Lifestyle

Stress - List the major stress factors in your life

School

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?

7am 9pm

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

Exercise/Activity	Times per wk	Intensity
Surfing	1-7	Depends on conditions
Tennis	2	Moderate
Running	2	Moderate

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?

Once

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

Vegetarian

How much water do you drink daily?

2litres

Do you consume coffee?

☐ Yes ☒ No

Do you consume tea?

☐ Yes ☒ No

Do you add sugar to tea or coffee?

No

Do you consume alcohol?

☐ Yes ☒ No

List any other drinks you consume

Combucha

Average Daily Diet

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

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Breakfast	Banana, scoop of protein powder, granola, peanut butter, honey, raspberries
Snack	Apple, dip and carrots
Lunch	Left overs, sandwich
Snack	Smoothie
Dinner	Vegetarian lasagna
Supper	Chocolate, icecream

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

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

Cramps, break outs

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






Sachi bridgeford

December 16, 2021

Audit Trail

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