



# New Client Questionnaire

---

## Your Details

**First Name**

Bridget

**Surname**

Gatt

**Address**

14 Mia Mia Way

**Suburb**

Torquay

**State**

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

**Email Address**

Bridgetgatt5@gmail.com

**Phone Number**

0456162787

**Age**

17

**Occupation**

Student, year 11

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

Health Concerns
Low iron
Fatigue
Afternoon dizziness

**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 often feel fatigued, but have been feeling a bit better since taking iron tablets (moltefer) but despite these supplements I have very low iron. I have been vegetarian for 2 years.

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

Family Member	Illness	Age
Father	High BP	54
Mother	Coeliac	56

## 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
Moltofer	1	Daily	July 2021	Fatigue

### 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

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?**

10pm. Wake: 7.30am

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

Exercise/Activity	Times per wk	Intensity

**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?**

2x 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

Vegetarian

How much water do you drink daily?

Average - 1 litre

Do you consume coffee?

☐ Yes ☒ No

Do you consume tea?

☒ Yes ☐ No

If yes, how many cups per day?

1

Do you add sugar to tea or coffee?

No

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	Toast and Vegemite or peanut
Snack	Popcorn or muffins or lentil chips
Lunch	Sandwich or salad wrap. Red apple.
Snack	
Dinner	Various. Tofu one cup. Lentil and eggplant. Salads, various
Supper	Chocolate and a hot tea or chai tea

Do you have any foods you dislike / avoid?

Meat. Mashed potatoes. Sultanas. Carrot. Capsicum, tomatoes.

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

1 = not confident; 10 = very confident

2

## FOR FEMALE PATIENTS

Are you still menstruating?

☒ Yes ☐ No

How many days do you have your period for?

4

How heavy is the flow?

- ☐ Light  
☒ Average  
☐ Heavy  
☐ Other

*If "Other", please specify*

State any premenstrual symptoms you suffer from

Lethargy, tender breasts

If you are on contraception, please list type

No

## 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





Bridget Gatt

December 13, 2021

## Audit Trail

Title	New Client Questionnaire
Document ID	61b2aa60398033154ce274a2
Status	Completed

## Document History

Status	Timestamp	Notes
 Viewed	12/13/2021 10:07:00 PM (AEDT)	Form viewed by Bridget Gatt (krisgatt888@gmail.com) IP Address: 120.148.155.185
 Viewed	12/13/2021 10:14:44 PM (AEDT)	Form viewed by Bridget Gatt (krisgatt888@gmail.com) IP Address: 120.148.155.185
 Signed	12/13/2021 10:40:29 PM (AEDT)	Form signed by Bridget Gatt IP Address: 120.148.155.185
 Completed	12/13/2021 10:40:29 PM (AEDT)	Completed by Bridget Gatt (krisgatt888@gmail.com) IP Address: 120.148.155.185