



New Client Questionnaire

Your Details

First Name

Sophie

Surname

Merrett

Address

36 Felix crescent Torquay

Suburb

Torquay

State

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

Email Address

Sophemerrett@gmail.com

Phone Number

0490090354

Age

18

Occupation

Student

List your current health concerns in order of importance

Health Concerns
Gut health
Skin
Bloating

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 want to understand gut health and how my nutrition can help it

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

School, friends, balancing work

Sleep - Please tick all that are applicable to you

- ☐ Difficulty falling asleep
☐ Snoring

- ☐ Teeth Grinding
☐ Waking during the night

☐ Waking unrefreshed☐ Insomnia**Sleep - What time do you normally wake-up and go to bed?**

Go to bed at about 10-11pm and wake at about 9:30

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

Exercise/Activity	Times per wk	Intensity
Gym	6-7 days	Medium to high

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?**

In the morning I get bad bowel movement

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?

Not sure

Do you consume coffee?

☒ Yes ☐ No

If so, how many cups per day?

Depends

Do you consume tea?

☒ Yes ☐ No

If yes, how many cups per day?

1 at night

Do you add sugar to tea or coffee?

No

Do you consume alcohol?

☒ Yes ☐ No

If so, how much, how often?

Social occasion Is

List any other drinks you consume

Average Daily Diet

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

Breakfast	Two eggs in a green wrap with avocado and a bit of tomato sauce
Snack	Protein bar or fruit
Lunch	Smoothie
Snack	
Dinner	Depends but usually has vegetable
Supper	

Do you have any foods you dislike / avoid?

Sea food

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?

7-8

How heavy is the flow?



Light



Average



Heavy



Other

If "Other", please specify

State any premenstrual symptoms you suffer from

Can't walk sometimes, major back ache, skin break out, legs hurt

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

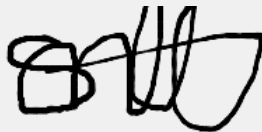
If "Other", please specify

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





Sophie Merrett

December 9, 2021

Audit Trail

Title	New Client Questionnaire
Document ID	61afd1ae398033086052db8f
Status	Completed

Document History

Status	Timestamp	Notes
 Sent	12/08/2021 8:27:10 AM (AEDT)	Form sent for signature/consent to Sophie Merrett (sophemerrett@gmail.com) IP Address: 194.193.49.195
 Viewed	12/09/2021 9:27:59 PM (AEDT)	Form viewed by Sophie Merrett (sophemerrett@gmail.com) IP Address: 101.181.3.166
 Signed	12/09/2021 9:36:32 PM (AEDT)	Form signed by Sophie Merrett IP Address: 101.181.3.166
 Completed	12/09/2021 9:36:32 PM (AEDT)	Completed by Sophie Merrett (sophemerrett@gmail.com) IP Address: 101.181.3.166