New Client Questionnaire

Your Details

First Name

Sarah

Surname

Karlberg

Address

47 Tareeda Way

Suburb

Ocean grove

State

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

Email Address

sarahjkarlberg84@hotmail.com

Phone Number

0408090429

Age

37

Occupation

Mental health Support Worker

List your current health concerns in order of importance

Health Concerns
Weight Gain
Sleeping issues
Back and body aches and pain, Cramps in legs
Mental Health

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

Just want to get my physical body healthy so my mental body follows, prevent from getting diseases like diabetes ect

Family History

Family History

Family Member	Illness	Age
Mother	diabetes	67
mother	Throat Cancer	67
Father	emphysema	69
Uncle	Aneurysm/Diabetes	58
Grandmother	Bowel Cancer/diabetes	71
great Aunt	Cancer	67

Personal Health History

Medical Diagnosis / Illness / Operations

Illness / Operation	Year Occurred
alopecia	1996

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
magnesium	x1 tablet	once a day	2021	Very low count in bloods
Vitamin D	x1 tablet 175 micrograms	once week	2021	Low count in blood

Lifestyle

Stress - List the major stress factors in your life

Sleep - Please tick all that are applicable to you

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

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

go to bed before 11pm wake up 8am

Exercise - Do you currently participate in any regular activity or program? ○ Yes ◉ No

Exercise Details

Exercise/Activity	Times per wk	Intensity
general walking	not often	low

Do you currently smoke tobacco? ○ Yes ◉ No

Digestive Health

Do you experience digestive difficulties?

- [x] Bloating
- [x] Cramping
- [ ] None
- [x] Wind
- [x] Reflux

How often do you have a bowel movement?

once a day or every second 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
Pine/ certain grasses	small reaction rash

Diet

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

nope

How much water do you drink daily?

1 lire

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?

every now and then not regular

Do you add sugar to tea or coffee?

yes 1 sugar or I add caramel to my take away coffee

Do you consume alcohol? ◉ Yes ○ No

If so, how much, how often?

only on a special occasion

List any other drinks you consume

diet soft drink/ sports drinks Powerade

Average Daily Diet

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

Breakfast	Coffee on the run sometimes a sandwich
Snack	chocolate or sugar snack
Lunch	usually don't get lunch unless its at a cafe with client
Snack	nil
Dinner	Make stirfys/ pasta/ Burgers/ soup/ Takeaways or no dinner
Supper	ice cream

Do you have any foods you dislike / avoid?

asparagus/

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

1 = not confident; 10 = very confident

6

FOR FEMALE PATIENTS

Are you still menstruating? ◉ Yes ○ No

How many days do you have your period for?

few air little as its due to my contraceptive Depo vera

How heavy is the flow?

- ◉ Light
- ○ Average
- ○ Heavy
- ○ Other

If "Other", please specify

State any premenstrual symptoms you suffer from

Bloating and cramps

If you are on contraception, please list type

Depo Vera 3 moths injection

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

sarah jane karlberg **October 15, 2021**

Audit Trail

Title	New Client Questionnaire
Document ID	61677f503980330edc1b80c0
Status	Completed

Document History

Status	Timestamp	Notes
Viewed	10/14/2021 1:16:52 PM (AEDT)	Form viewed by Sarah Karlberg (sarahjkarlberg84@hotmail.com) IP Address: 1.136.17.80
Viewed	10/14/2021 1:17:09 PM (AEDT)	Form viewed by Sarah Karlberg (sarahjkarlberg84@hotmail.com) IP Address: 40.94.35.38
Viewed	10/15/2021 11:27:48 AM (AEDT)	Form viewed by Sarah Karlberg (sarahjkarlberg84@hotmail.com) IP Address: 120.148.158.169
Viewed	10/15/2021 11:28:15 AM (AEDT)	Form viewed by Sarah Karlberg (sarahjkarlberg84@hotmail.com) IP Address: 40.94.226.57
Signed	10/15/2021 11:51:43 AM (AEDT)	Form signed by sarah jane karlberg IP Address: 120.148.158.169
Completed	10/15/2021 11:51:43 AM (AEDT)	Completed by Sarah Karlberg (sarahjkarlberg84@hotmail.com) IP Address: 120.148.158.169