



New Client Questionnaire

Your Details

First Name

Kylie

Surname

Mitchell

Address

65 Foster Mirboo Road

Suburb

Foster North

State

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

Email Address

kymitch2@bigpond.com

Phone Number

0409009392

Age

49

Occupation

administration

List your current health concerns in order of importance

Health Concerns
rosacea/acne
bloating and gas
general overall health, wellness and 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

I've tried for a couple of years now to treat my rosacea & acne with topical things, supplements, gut health kits from Love Ya Guts online. Then a beautician treatment for several months last summer. She recommended a laser clinic and upon my visit there, she gave me a print out of foods to avoid, foods to include and that's where my confusion set in!

Family History**Family History**

Family Member	Illness	Age
Mum	chronic coughing diabetes	73
Dad	alcoholism	76

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
Happy Hormones	2 capsules	daily	February 2021	irregular period & mood swings
Evening Primrose	2 capsules	daily	approx 6 years ago	PMT symptoms skin care
Clear Skin	1 capsule	daily	January 2021	acne
Omega 3 triple	1 capsule	daily	19th July 2021	skin care
Healthy Gut powder	1 tablespoon	daily	6th July 2021	gut repair
Tumeric ginger black pepper with probiotics	20mls	daily	6th July 2021	gut repair
bone broth	2 tsps	daily	6th July 2021	gut repair

Lifestyle

Stress - List the major stress factors in your life

a busy admin/reception job at a Primary School, Covid, teachers and students not coping
a professional husband that suffers anxiety
a 20 year old son recently moved to Melbourne, studying and working part time.
a 17 year old son doing VCE from home
power outages recently for 7 days which caused me huge stress

Sleep - Please tick all that are applicable to you

- | | |
|--|---|
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Teeth Grinding |
| <input checked="" type="checkbox"/> Snoring | <input checked="" type="checkbox"/> Waking during the night |
| <input checked="" type="checkbox"/> Waking unrefreshed | <input type="checkbox"/> Insomnia |

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

bed time 9.30pm, fall asleep no worries, wake time 6.30am

Exercise - Do you currently participate in any regular activity or program?

☒ Yes ☐ No

Exercise Details

Exercise/Activity	Times per wk	Intensity
walking	3-4	moderate
yoga	1-2	moderate

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?

usually once a day, 3 times at the moment

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
dairy	congestion, runny nose, coughing
hayfever to dust/mould	sneezing, itchy watering eyes

Diet

Do you follow a special diet?

e.g. gluten free, vegetarian etc

I've been following a dairy free, kind of gluten free diet for 3 weeks now

How much water do you drink daily?

1.5 litres on average

Do you consume coffee?

☒ Yes ☐ No

If so, how many cups per day?

1-2

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?

2 glasses Friday and Saturday nights, maybe 1 or 2 glasses during the week

List any other drinks you consume

Average Daily Diet

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

Breakfast	old: oats, berries, honey, nuts & coconut new: green smoothie with spinach, berries, psyllium, gut powders and flaxseed, almond milk
Snack	old: soy latte, muesli bar new: almond latte, nuts- walnuts, pistachios, macadamias

Lunch	old: salad, tuna, chicken or meat, or stirfry with rice, maybe toasted sandwich new: soup, salad with salmon patties
Snack	old: black tea with an apple, or chocolate new: bone broth with vege sticks and almond spread
Dinner	old: meat, potato, beans, peas, corn, or pasta, rice etc, salad some nights new: meat, salad/veg with no rice, pasta, corn, beans, peas, pot
Supper	hasn't changed, herbal tea with good dark chocolate

Do you have any foods you dislike / avoid?

melon

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

1 = not confident; 10 = very confident

10

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

mood swings, acne, bloating

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

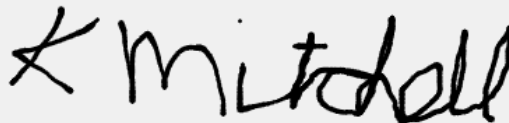
If "Other", please specify

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





Kylie Mitchell

July 23, 2021

Audit Trail

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