New Client Questionnaire

Your Details

First Name

Sam

Surname

Sexton

Address

16 Mayfield Cres

Suburb

St Albans Park

State

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

Email Address

samanthasextonj@gmail.com

Phone Number

0448154053

Age

30

Occupation

Mental Health

List your current health concerns in order of importance

Health Concerns
Gut health
Upset stomach after food

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

Understand how to repair my gut and maintain long term

Family History

Family History

Family Member	Illness	Age
Mom	Colitis	57
Brother	Crohn's	

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
Nexium	40mg	1 daily	Sept 8	Acid

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

- [x] Difficulty falling asleep
- [ ] Teeth Grinding

- [ ] Snoring
- [x] Waking unrefreshed
- [ ] Waking during the night
- [ ] Insomnia

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

6:45am and 9:30/10pm

Exercise - Do you currently participate in any regular activity or program? (●) Yes ( ) No

Exercise Details

Exercise/Activity	Times per wk	Intensity
Run/walk	3-4	Medium (on hold past 6 weeks)
Weight training	3-4	Medium (on hold for past 6 weeks)

Do you currently smoke tobacco? ( ) Yes (●) No

Digestive Health

Do you experience digestive difficulties?

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

How often do you have a bowel movement?

Normal 1 time per day. Past 6 weeks 3-6 depending

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
Lactose	Upset stomach
Dairy	Upset stomach

Diet

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

Low meat intake. If meat usually chicken.

How much water do you drink daily?

1.5L

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

If so, how much, how often?

2-3 beverages 2 times a week

List any other drinks you consume

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

Breakfast	Smoothie: spinach blueberries banana peanut butter almond milk
Snack	Homemade banana bread or nuts
Lunch	Quinoa with salmon or Cous cous with beans and veg
Snack	Popcorn or bliss ball
Dinner	Chicken/ fish and veg and rice.
Supper	yogurt and chocolate

Do you have any foods you dislike / avoid?

Sardines (trying to like them)

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?

3

How heavy is the flow?

- (●) Light
- ( ) Average
- ( ) Heavy
- ( ) Other

If "Other", please specify

State any premenstrual symptoms you suffer from

No

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.

Samantha Sexton

X

Samantha Sexton **September 17, 2021**

Audit Trail

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