



New Client Questionnaire

Your Details

First Name

Brock Darcy

Surname

Stefani

Address

500 Harding Lawson Rd

Suburb

Fish Creek

State

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

Email Address

rayandbec@aanet.net.au

Phone Number

0438832394

Age

18

Occupation

Dairy Farmer

List your current health concerns in order of importance

Health Concerns
Random stomach pains mostly at night.
Acne but has cleared but have scarring. Having treatment at VC Dermal. Led light therapy and skin peels About to start needling for scarring.

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

Brock at 2 days old was taken to RCH and was on a high dose of antibiotics but they couldn't find what was wrong with him also he was only 6 weeks old when I stopped breast feeding him due to me starting chemotherapy. Ever since then he has had trouble with his bowel motions. Will explain more in appointment. Colloidal silver, doTERRA Digestzen oil, Kinesiology wheat free diet at a young age like about 5 or 6 years old.

Family History**Family History**

Family Member	Illness	Age
Mum	Non Hodgkins Lymphoma	28
Brother	Hodgkins Disease	17

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
JSHEALTH skin & digestion	1	Twice a day	4 months	
Fish oil triple strength	1	Twice a day	6 months	

Lifestyle

Stress - List the major stress factors in your life

No

Sleep - Please tick all that are applicable to you

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

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

5:30am / 10:30pm

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

Exercise/Activity	Times per wk	Intensity
Footy Training	2	High intensity
Game of football	1	High intensity
Work	6	Medium intensity

Do you currently smoke tobacco?☐ Yes ☒ No**Digestive Health****Do you experience digestive difficulties?**

- | | |
|--|--|
| <input type="checkbox"/> Bloating | <input checked="" type="checkbox"/> Wind |
| <input checked="" type="checkbox"/> Cramping | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> None | |

How often do you have a bowel movement?

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

Diet

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

No

How much water do you drink daily?

1 litre

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?

1

Do you add sugar to tea or coffee?

Yes 1 1/2

Do you consume alcohol?

☒ Yes ☐ No

If so, how much, how often?

1 or 2 drinks 3 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	3 slices of toast
Snack	
Lunch	Sandwich or pie or pizza
Snack	
Dinner	Meat salad vegetables pasta dish
Supper	

Do you have any foods you dislike / avoid?

No

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

1 = not confident; 10 = very confident

4

FOR FEMALE PATIENTS

Are you still menstruating?

☐ Yes ☒ No

How many days do you have your period for?

How heavy is the flow?

- ☐ Light
☐ Average
☐ Heavy
☐ Other

If "Other", please specify

State any premenstrual symptoms you suffer from**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

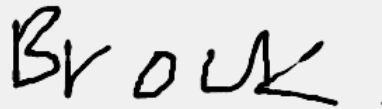
If "Other", please specify

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





Brock Stefani

August 23, 2021

Audit Trail

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