



# New Client Questionnaire

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## Your Details

**First Name**

Kate

**Surname**

Martin

**Address**

35 North Valley Road

**Suburb**

Highton

**State**

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

**Email Address**

katepmartin19@gmail.com

**Phone Number**

0476277434

**Age**

15

**Occupation**

part-time pre professional dancer

**List your current health concerns in order of importance**

Health Concerns
Severe Digestive Issues
Hair Loss
Fatigue
Body Composition

**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

After a bad run in with gluten my digestive system stopped working properly I had begun passing food whole. I was desperate for relief from the excruciating bloating so I tried a month long gut reset diet plan made for people with digestive issues and/or IBS by Bethany Ugarte, which helped me a lot, the diet was mostly liquid/pureed food. At this point I begun putting on weight as just before this I lost a lot of weight and became further underweight due to what I believe to be a combination of an inability to absorb nutrients and if I'm being honest, disordered eating. I am now eating solid food along with following advice from after the program. (e.g. foods to include and avoid).

As stated earlier I am a pre-professional dancer dancing 6-7 days a week and would like to better fuel my training through my diet. I have also been working towards some physique goals of changing my body composition, building muscle and lowering my body fat percentage but I feel like I need some advice from a professional on how to achieve this, especially in a healthy way.

## Family History

### Family History

Family Member	Illness	Age
Grandfather	Fatty Liver disease & Type 2 Diabetes	Deceased
Mother	Endometriosis	49
Grandmother	Heart Disease	86
Father's side of family	Colon Cancer	

## Personal Health History

### Medical Diagnosis / Illness / Operations

Illness / Operation	Year Occurred
Fatty Liver spots & failed liver function test	2017 and 2018
High Insulin	2017 and worse in 2018
Many Surgeries Due to impacted bowel	From birth to 10yrs old?
Suspected PCOS (Later Negative Diagnosis)	First suspected in 2017 by doctor went back for symptoms this year, had tests with a negative diagnosis.
Suspected Hirschsprung's disease when born, Positive test, later tested negative	2006
Gluten Intolerance/Coeliac Disease	2017

**Medications**

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason
Osmolax	17g	Used to have to take it every day, now just when needed.	2017	I've had to be on laxatives since I was born to prevent constipation however for about a year I have only had to take it when I feel off.

**Supplements**

List all supplements you're currently taking including vitamins, herbs, minerals.

Supplement	Dose	Frequency	Start Date	Reason
Iron polymaltose	370mg	Once a Day	June 2021	Blood tests showed Iron Deficiency
Vitamin C	1000mg	Once a Day	July 2021	Help with Iron absorption
L-Glutamine	750mg	1-4 Times a Day	March/April 2021	For Digestive Digestive Support & Muscle health and recovery
Collagen		When included in meals	March/April 2021	Digestive Support and Hair Health

## Lifestyle

**Stress - List the major stress factors in your life**

**Sleep - Please tick all that are applicable to you**

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

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

(During school terms) Bed around 11.30 wake around 7 on a good day

**Do you currently smoke tobacco?**

☐ Yes ☒ No

## Digestive Health

**Do you experience digestive difficulties?**

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

**How often do you have a bowel movement?**

Varies a lot, on average 1-2 times a 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
Gluten	Cramping, Bloating, inability to digest food after for long periods of time, face, mouth and ears become red and irritated, Joint stiffness
Sensitive to Dairy	Just doesn't agree with me

## Diet

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

Gluten Free, Vegetarian

**How much water do you drink daily?**

1-2 Litres

**Do you consume coffee?** ☒ Yes ☐ No

*If so, how many cups per day?*

Not much nowadays used to be around 2 a day

**Do you consume tea?** ☒ Yes ☐ No

*If yes, how many cups per day?*

Once again not much nowadays used to be 2-3 a day, mostly decaf green when I do

**Do you add sugar to tea or coffee?**

Never

**Do you consume alcohol?** ☒ Yes ☐ No

*If so, how much, how often?*

Occasionally

**List any other drinks you consume**

Sports drinks on doctors recommendation for low blood pressure when training when blood pressure is particularly bad

**Average Daily Diet**

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

Breakfast	Protein Oats with strawberries, cherries, blueberries and Yoghurt
Snack	
Lunch	2 Hard Boiled Eggs with Spinach
Snack	
Dinner	Tofu with Large serve of Steamed Broccoli, Carrot, Zucchini and Green Beans
Supper	Greek Yogurt with Fruit and Nut butter

**Do you have any foods you dislike / avoid?**

Not Particularly Except for meat

**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?

Extremely Varied 2-7 days with an average of 4

**How heavy is the flow?**

- ☒ Light  
☐ Average  
☐ Heavy  
☐ Other

*If "Other", please specify*

**State any premenstrual symptoms you suffer from**

Cramping, bloating/water retention, irrationally emotional

**If you are on contraception, please list type**

The Combined Pill (Levonorg/Ethinylest), Brand changes but currently Microgynon.

**OTHER****How did you find out about my practice?**

- ☐ Referral from friend or other  
☐ Internet Search  
☐ Social Media  
☒ Other

*If "Other", please specify*

Sister was a patient

**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





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**Kate Martin****July 9, 2021**

## Audit Trail

Title	New Client Questionnaire
Document ID	60e2d375398033045028acef
Status	Completed

## Document History

Status	Timestamp	Notes
 Viewed	07/06/2021 3:01:59 PM (AEST)	Form viewed by Kate Martin (d.martin@ccg.vic.edu.au) IP Address: 180.222.4.57
 Viewed	07/09/2021 2:12:19 PM (AEST)	Form viewed by Kate Martin (d.martin@ccg.vic.edu.au) IP Address: 180.222.4.57
 Signed	07/09/2021 3:26:47 PM (AEST)	Form signed by Kate Martin IP Address: 180.222.4.57
 Completed	07/09/2021 3:26:47 PM (AEST)	Completed by Kate Martin (d.martin@ccg.vic.edu.au) IP Address: 180.222.4.57