New Client Questionnaire

Your Details

First Name

Inga

Surname

Muribo

Address

29 Storrer Ave

Suburb

Torquay

State

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

Email Address

ingamuribo@gmail.com

Phone Number

0466561776

Age

32

Occupation

Business manager , Manuko

List your current health concerns in order of importance

Health Concerns
Optimising immune system
Optimising health for conception

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

-

Family History

Family History

Family Member	Illness	Age
-		

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
Vitamin D	1 spray	1 x day		
Green drink	1 tsp	1 x day		
Iodine	3 drops	3 x week		

Lifestyle

Stress - List the major stress factors in your life

Move - personal and business. Covid Restrictions and measures locally and globally.

Sleep - Please tick all that are applicable to you

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

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

10pm - 6:30am

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

○ Yes ◉ No

Exercise Details

Exercise/Activity	Times per wk	Intensity

Do you currently smoke tobacco?

○ Yes ◉ No

Digestive Health

Do you experience digestive difficulties?

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

How often do you have a bowel movement?

2 x 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?

2 l

Do you consume coffee? ○ Yes ◉ No

Do you consume tea? ○ Yes ◉ No

Do you add sugar to tea or coffee?

No

Do you consume alcohol? ○ Yes ◉ No

List any other drinks you consume

Hot Chocolate and chai

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

Breakfast	Discuss in person if relevant
Snack	
Lunch	
Snack	
Dinner	
Supper	

Do you have any foods you dislike / avoid?

Will think about this

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

Cramping

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

Inga Muribo **August 19, 2021**

Audit Trail

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