



New Client Questionnaire

Your Details

First Name

Caroline

Surname

Flanagan

Address

10 Beales Street

Suburb

Torquay

State

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

Email Address

Carolineflan@hotmail.com

Phone Number

0407520088

Age

49

Occupation

Customer Engagement

List your current health concerns in order of importance

Health Concerns
Bloating
Endometriosis
Not sleeping well

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

No treatments in the past, would like to reset and review where I can make changes in diet/lifestyle.

Family History**Family History**

Family Member	Illness	Age
Mum	Breast cancer	78
Sister 1	Kidney issues, unexplained blood clots	53
Sister 2	Charcot Marie Tooth	46

Personal Health History

Medical Diagnosis / Illness / Operations

Illness / Operation	Year Occurred
Endometriosis	Ongoing

Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason
Nil				

Supplements

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

Supplement	Dose	Frequency	Start Date	Reason
Nil				

Lifestyle

Stress - List the major stress factors in your life

Work

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?

Wake up 6.30/Sleep 9.30 -10pm

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?

3-4 times weekly

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
Chickpeas/lentils	Bloating

Diet**Do you follow a special diet?**

e.g. gluten free, vegetarian etc

No

How much water do you drink daily?

2-3 litres

Do you consume coffee?☒ Yes ☐ No*If so, how many cups per day?*

2

Do you consume tea?☐ Yes ☒ No**Do you add sugar to tea or coffee?**

No

Do you consume alcohol?☒ Yes ☐ No*If so, how much, how often?*

4 drinks per week

List any other drinks you consume

Mineral water

Average Daily Diet

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

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Breakfast	2 slices of bread with vegimite/avacado/jam
Snack	Biscuit or cake or piece of chocolate
Lunch	Leftovers, salad or sandwich
Snack	Same as AM
Dinner	Meat and veg/pasta/stirfry/fish
Supper	NA

Do you have any foods you dislike / avoid?

Chickpeas and lentils avoid

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

1 = not confident; 10 = very confident

8

FOR FEMALE PATIENTS

Are you still menstruating?

☒ Yes ☐ No

How many days do you have your period for?

6

How heavy is the flow?

- ☐ Light
☐ Average
☒ Heavy
☐ Other

If "Other", please specify

State any premenstrual symptoms you suffer from

Bloating, moods

If you are on contraception, please list type

No

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






Caroline Flanagan

June 20, 2021

Audit Trail

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