



New Client Questionnaire

Your Details

First Name

Grace

Surname

Blood

Address

180 Noble Street

Suburb

Newtown

State

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

Email Address

graceblood5@gmail.com

Phone Number

0457153223

Age

19

Occupation

Student

List your current health concerns in order of importance

Health Concerns
Bloating
Gut Issues
Tiredness
Headaches

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

Discomfort from constant bloating and gut issues.

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

Lifestyle

Stress - List the major stress factors in your life

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Sleep - Please tick all that are applicable to you

- ☐ Difficulty falling asleep
☐ Snoring

- ☐ Teeth Grinding
☐ Waking during the night

☐ Waking unrefreshed☐ Insomnia**Sleep - What time do you normally wake-up and go to bed?**

Wake up: 6.30-7am Go to Bed: 10.30

Do you currently smoke tobacco?

☐ Yes ☒ No**Digestive Health**

Do you experience digestive difficulties?

☒ Bloating☐ Wind☒ Cramping☐ Reflux☐ None

How often do you have a bowel movement?

Once every two days

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?

2L

Do you consume coffee?

☒ Yes ☐ No

If so, how many cups per day?

1-2

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?

Once 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	Granola and Yogurt
Snack	Coffee
Lunch	Sandwich
Snack	Museli Bar

Dinner	-
Supper	-

Do you have any foods you dislike / avoid?

Seafood

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?

3-4 days

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

Yaz Pill

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




Grace Blood

June 22, 2021

Audit Trail

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