the passionate nutritionist

Mel Bald
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NEW CLIENT INTAKE FORM

YOUR DETAILS

Date Form Completed 17-Mar-20

First Name	Dina
Surname	Dasic
Address	28 Brettim Boulevard
Suburb	Grovedale
State	Victoria
Post Code	3216
Phone	0418227372
Email	dina.dasic@gmail.com
Date of Birth	12-Jan-19
Age	32
Country of Origin	Serbia
Martial Status	Married
# Children	0
Occupation	Business Development Manager
Emergency Contact	Vernon Van Schalkwyk
Contacts Phone	0478806042

How did you find out about my practice?

We used to work together :)

Please state any known drug allergies

Drug	*Reaction*

Please state any FOODS/INHALANTS (Dust, pollens, moulds) that you know that you are allergic to and what symptoms they produce

Food/Inhalant	*Symptoms*
Unsure	I sometimes get an upset stomach, lots of gas and bloating and a bit of di

PREVIOUS HISTORY

Please list, in order, any major illnesses and operations you have had in the past, starting from your childhood. (Eg. Bronchitis, glandular fever, pneumonia, astham, eczema, high blood pressure, hepatitis, sinusitis or removal of tonsils, appendix gallbladder etc.)

Illness/Operation	*Year This Occurred*
Severe bronchitis	1992
High cholesterol	2011
Knee arthroscope	2005
Knee reconstruction	2011
L5S1 disc bulge	2010
Many other skeletal injuries	
Vitamin D severe deficiency	2012

Please list any MEDICATION that you are taking regularly, including any pharmaceuticals, vitamins or minerals. Please give details of the dosage and frequency of each medication.

Medications/Supplements (Name & Brand)	Dose (mg)	# per Day	Reason for Taking	Started Taking When?
Yasmin pill		1	Contraception	2015

FAMILY HISTORY

Please list any major illnesses in your nearest relatives, Ie. Parents, grand-parents, siblings etc. Illnesses such as tuberculosis, eczema, asthma, heart disease, high blood pressure, diabetes, cancer or anything else. Please state the relative and the illness which has affected that relative. (Eg. Grandmother - breast cancer).

Relative	*Illness*	*Age of Diagnosis*
Mother	N/A	
Father	N/A	

YOUR VISIT TODAY

Please identify your top priorities for your visit today.

1.	Figure out what to eat to ensure all nutrients are covered as want to prepare for gettir
2.	Get yummy healthy recipe ideas
3.	Determine if I need to be taking any supplements
4.	

Please state when your symptoms started and describe any triggering or aggravating factors to these symptoms.

I have a very sensitive stomach, mainly to highly processed food (especially junk food and low quality food). Often get bloated and gassy if I eat those types of foods. Sometimes I do get a runny stool when food does not agree with me.

Outline any factor that in any way affects your symptoms either making them worse or better (Please state which).

Give details of any previous treatments you have had and the results of any investigations you have had so far.

N/A

CURRENT CONDITIONS

Do you have any medically diagnosed conditions or injuries?

N/A

STRESS FACTORS

Please state any major STRESS FACTORS OR MAJOR WORRIES in your life. Eg. Problems at work, relationship problems, sick relatives etc.

1.	Work intensity
2.	Studying MBA - not as stressful in itself, just finding the time
3.	Time management and fitting everything in
4.	
5.	

EXERCISE

Do you currently participate in any regular activity or program? (Either on your own or in a formal class?) — Yes

Details of your exercise (Number of times per week and intensity)

Exercise/Activity	Times per Week	Intensity
ing 10 mins of cardio at the start and then weights training for the	3	Medium/High
PT with Vernon	1	Medium/High
Walking the dogs	5	Low

SLEEP

Do you sleep well? — Yes

Please tick all that are applicable to you.

Difficulty falling asleep	☐	Waking during the night	✔
Teeth grinding	☐	Waking unrefreshed	☐
Snoring	☐	Insomnia	☐

What time do you normally go to bed? — 10pm

What time do you normally wake up? — 6am

SMOKING

Do you currently smoke tobacco? — No

Have you been a regular smoker in the past? — No

If yes, state the average number of cigarettes per day?

What year did you start?

What year did you stop?

BOWEL FUNCTIONS

How often do you open your bowels on average? (Eg. Once every 1 to 2 days etc)

Once a day

How would you describe your bowel movements? — Mixed: Loose & Constipated

Do you use laxatives? — No

State what type of laxatives and how much you use?

Do you suffer abdominal bloating? — Yes

Flatulence (Wind)? — Yes

Has there been ANY CHANGE IN YOUR BOWEL HABIT recently? — No

State the change in bowel habit?

ALCOHOL

How would you describe your alcohol drinking habits? Minimal Socially

WEIGHT

Have you lost ANY WEIGHT recently? No

If yes, how much? | Over what period?

What is the heaviest WEIGHT you have been in your life? 118kg

What period was this? Last year at some point

FOOD INTAKE

Do you follow a special diet (Eg. Vegetarian, vegan, gluten free)? If yes, please describe.

N/A - eat everything

How long have you been on this diet?

DRINKS

State the number of CUPS OF TEA you drink per day (and any sugar)?

1 - no sugar

State the number of CUPS OF COFFEE you drink per day (and any sugar)?

1 - no sugar

State the amount and type of SOFT DRINKS/ SPORTS DRINKS/ ENERGY DRINKS consumed per day

0 - only if eating out would have a coke zero with meal if not having alcohol (otherwise 1 red wine)

Do you drink water daily? Yes

If yes, state the amount of WATER consumed per day. 2.4L on average

FOOD

List your diet on an average day (Including quantity where known. Eg. 2 slices bread, 1/2 cup rice etc)

Breakfast	*Morning Tea*
Usually 2 slices of sourdough bread with something on top - either goats cheese and ham, or chicken pate. Would have a few tablespoons of greek yogurt with this too. Or, museli and yogurt	N/A

Lunch	*Afternoon Tea*
Two poached or fried eggs, one piece of toast, either bacon or ham, mushrooms, sometimes spinach	In the past when in the office I would have sweets in the afternoon, usually some form of chocolate. Working from home the sugar intake has been minimal. If I don't buy it I don't eat it. Museli bar on occasion if hungry.

Dinner	*Supper*
Some sort of meat (alternate salmon, chicken, beef and pork) and a mixed green salad and usually brocolinni that was steamed and then lightly suateed on the pan (or zucchini cooked on the pan). On Saturdays we usually have dinner with my parents and that usually has potatoes in it in addition to salad and some meat	N/A

State the amount consumed of the following per day/week.

	Day	Week
Chocolates		100g
Lollies/Sweets		N/A
Cakes		N/A
Sweet Biscuits		200g?

How often and what type of take-away food do you eat?

We usually have take-away on Friday nights. This is usually pizza or dumplings. If at the office, I will buy lunch as am really fussy with reheated food. The lunch food varies a lot.

I have an overreliance on carb based foods.

Do you have any foods you dislike/avoid?

Fish and seafood - I like salmon and white fish that is not too fishy, canned tuna and calamari.

On a scale of 1 to 10, how confident are you preparing your own meals at home?
1 = Not confident at all and 10 = Very confident: 10

FOR FEMALE PATIENTS

PERIODS

Are you still menstruating? Yes

How many days do you have your period for? 5

Average number of days in your cycle? 28

Are your periods REGULAR (Within a day or two of expected time)? Yes

Please indicate how HEAVY the flow of your period is. Heavy With Clots

State any PREMENSTRUAL SYMPTOMS you suffer from.

Bloating, feeling heavy, retain more water.

How often do you suffer from vaginal irritation/itch/infection? Never

Please state approx. date of your last pap smear (If still menstuating) September 2021

Have you had a tubal sterilisation procedure? No

Have you had a hysterectomy? No

If you are taking HORMONES, please state the name and dosage.

CONTRACEPTION

Have you ever taken the ORAL CONTRACEPTIVE PILL? If so, for how long?

Yes. Between 2008 and 2010. From 2015 to now.

If you are currently using the pill, please state the name of it. Yasmine

Are you using any other forms of contraception (Eg. Mirena, Impanon etc)

No

FOR MALE PATIENTS

Have you noticed any change in the strength of urine flow?	No
Have you noticed any difficulty in stopping or starting urine flow?	No
Do yu have any problems maintaining an erection?	No
Have you had any prostate investigations performed?	No
Were these blood or physical examination?	Not Applicable

Detail any abnormal findings?

Would you like to receive my monthly email newsletter (Health tips, research and recipes)?	Please Choose

INFORMED CONSENT

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.

Patient Name	Dina Dasic
Patient or Parent Signature	
Date Signed	17-Mar-20

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