



# New Client Questionnaire

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## Your Details

**First Name**

Suzi

**Surname**

Radunovic

**Address**

4/100-108 West Fyans St

**Suburb**

Newtown

**State**

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

**Email Address**

radunovic1@hotmail.com

**Phone Number**

0403 306 238

**Age**

53

**Occupation**

Admin/accounts

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

Health Concerns
Weight gain
Upset stomach
Tiredness
Moody
Bloating

**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

Rapid weight gain, flatulence, bloating

**Family History****Family History**

Family Member	Illness	Age

## Personal Health History

### Medical Diagnosis / Illness / Operations

Illness / Operation	Year Occurred
High blood pressure	2006

### Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason
Reaptan 10mg/5mg	1	Daily		

### Supplements

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

Supplement	Dose	Frequency	Start Date	Reason
Vit C	1000mg	1 daily		
echinacea forte		1 daily		
Fish Oil Tab		1 daily		
Panadol Osteo		2x2 daily		

## Lifestyle

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

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

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

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

sleep around 9.30-10.00pm and wake up 5.30 if exercising or 7.00 if not

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

☒ Yes ☐ No

**Exercise Details**

Exercise/Activity	Times per wk	Intensity
swimming	3	medium..20 laps of 25m pool
walking	4	30 min medium

**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 type="checkbox"/> Cramping            | <input type="checkbox"/> Reflux          |
| <input type="checkbox"/> None                |  |

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

once a day..sometimes more often

**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?**

1.5 lts

**Do you consume coffee?**

☒ Yes ☐ No

*If so, how many cups per day?*

4

**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

**List any other drinks you consume**

**Average Daily Diet**

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

Breakfast	See list at appointment
Snack	
Lunch	
Snack	
Dinner	
Supper	

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

No

**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?

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

## 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

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Suzi Radunovic







July 16, 2022






## Audit Trail

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