



New Client Questionnaire

Your Details

First Name

Robin

Surname

Cook

Address

28 The Avenue

Suburb

Belmont

State

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

Email Address

katchme_kate@hotmail.com

Phone Number

0431 929 963 (Kate/Mother)

Age

13

Occupation

Student

List your current health concerns in order of importance

Health Concerns
Acne - skin health
Learning about processed food, additives, artificial sweeteners, sugar, starch, Corn syrup etc. eg. Boba Tea, MSG.
Growing Needs/Energy - diet/exercise/protein and fat/sleep
Gut health and wellbeing
These are just ideas. Would love for him to hear your outlook on food/diet/health and for him to be able to ask any questions.

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

Robin has only had acne for >6mths but scarring is appearing. Tried no dairy for 2 weeks, no change. Now trying Antibiotics.

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
Doxylin	50mg	1 day	8 June?	Acne/scarring

Supplements

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

Supplement	Dose	Frequency	Start Date	Reason
Vit C	2 tablets	1 day		Immune Support
Childrens Multi	2 tablets	1 day		Health support

Lifestyle

Stress - List the major stress factors in your life

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?

10.30pm - 7.30 School days, 12pm - 10/11 Weekends

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

☒ Yes ☐ No

Exercise Details

Exercise/Activity	Times per wk	Intensity
School Sports		

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?

Not sure this info?

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?

Not sure?

Do you consume coffee?

☐ Yes ☒ No

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

Smoothies, Boba Tea occasionally, Tea, Water, Milk.

Average Daily Diet

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

Breakfast	Either 2 slice bread/ Natural Peanut B or Corn Flakes/Milk
Snack	Smoothies - loves them. Daily blueberries or Mango smoothies.
Lunch	Bread, Tasty cheese, butter
Snack	Apple; 2 Minute noodles; Bread & Hummus
Dinner	Meat Veg Stews/Rice; Chicken/Veg Soup w/bone broth; Tacos; Chicken Curry/Rice; Bolognese Pasta; Always some green veg/herbs each dinner.
Supper	Yoghurt/Fruit smoothie on weekdays; ice cream on Fri/Sat/Sun night.

Do you have any foods you dislike / avoid?

Accepts nearly all dinners with most ingredients now :) We use homegrown greens.

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

1 = not confident; 10 = very confident

Robin loves cooking but also loves flavour - often centres on bread/cheese/meat. Could eat more fruit, decrease sugar.

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

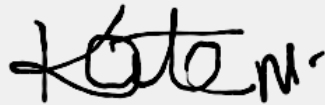
Eat Well, Live Well. Much appreciate your time.

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







Kate mcmenomy





June 30, 2022

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