

NEW CLIENT INTAKE FORM

YOUR DETAILS		Date Form Completed
First Name		
Surname		
Address		
Suburb		
State		Post Code
Phone		
Email		
Date of Birth		Age
Country of Origin		
Marital Status		# Children
Occupation		
Emergency Contact		
Contacts Phone		

How did you find out about my practice?

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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

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, asthma, eczema, high blood pressure, hepatitis, sinusitis or removal of tonsils, appendix gallbladder etc.)

[illegible]

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.

[illegible]

FAMILY HISTORY

Please list any major illnesses in your nearest relatives, i.e. 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).

[illegible]

YOUR VISIT TODAY

Please identify your top priorities for your visit today.

1.	
2.	
3.	
4.	

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

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

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

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CURRENT CONDITIONS

Do you have any medically diagnosed conditions or injuries?

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STRESS FACTORS

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

1.	
2.	
3.	
4.	
5.	

EXERCISE

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

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

Exercise/Activity	Times per Week	Intensity

SLEEP

Do you sleep well?

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?

What time do you normally wake up?

SMOKING

Do you currently smoke tobacco?

Have you been a regular smoker in the past?

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)

How would you describe your bowel movements?

Do you use laxatives?

State what type of laxatives and how much you use?

Do you suffer abdominal bloating?

Flatulence (Wind)?

Has there been ANY CHANGE IN YOUR BOWEL HABIT recently?

State the change in bowel habit?

ALCOHOL

How would you describe your alcohol drinking habits?

WEIGHT

Have you lost ANY WEIGHT recently?

If yes, how much?

Over what period?

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

What period was this?

FOOD INTAKE

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

How long have you been on this diet?

DRINKS

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

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

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

Do you drink water daily?

If yes, state the amount of WATER consumed per day.

FOOD

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

Breakfast	Morning Tea
<input type="text"/>	<input type="text"/>
Lunch	Afternoon Tea
<input type="text"/>	<input type="text"/>
Dinner	Supper
<input type="text"/>	<input type="text"/>

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

	Day	Week
Chocolates		
Lollies/Sweets		
Cakes		
Sweet Biscuits		

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

Do you have any foods you dislike/avoid?

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

FOR FEMALE PATIENTS

PERIODS

Are you still menstruating?

How many days do you have your period for?

Average number of days in your cycle?

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

Please indicate how HEAVY the flow of your period is.

State any PREMENSTRUAL SYMPTOMS you suffer from.

How often do you suffer from vaginal irritation/itch/infection?

Please state approx. date of your last pap smear (If still menstruating)

Have you had a tubal sterilisation procedure?

Have you had a hysterectomy?

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?

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

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

FOR MALE PATIENTS

Have you noticed any change in the strength of urine flow?

Have you noticed any difficulty in stopping or starting urine flow?

Do you have any problems maintaining an erection?

Have you had any prostate investigations performed?

Were these blood or physical examination?

Detail any abnormal findings?

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

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

**Patient or Parent
Signature**

Date Signed