Administrative Details

Date:……..

Title:…… Surname:…….…….. First Name:……..…..

DOB:…….Address:…….…..……

Suburb:……. Postcode:…….……..

☐ Phone: H:……... ☐ M:……..….☐ Email:……....
(for reminders online bookings)

GP name:…….. Address:……..……

……Phone:……

Are you under the care of another health care professional (ie; specialist) if yes give details:

……...……

How did you find out about Davis Dietetics?:……...……
Do you have a GP referral?.....

Would you like to be on the mailing list for Email Newsletters 4 times a year:

Yes	No

Privacy policy:-
We are committed to protecting your privacy. We will only use the information that we collect about you lawfully. Personal information will not be used for other than for contact information. It will not be given to any 3rd party. Data collected may be used for research purposes. We will not e-mail you in the future unless you have given us your consent. Your GP may be contacted regarding the progress of your appointment, please let us know if you do not want your GP contacted. For EPC referrals, it is a requirement for the health practitioner to write a report to your GP please let us know if you have and concerns about this. The personal information which we hold will be held securely in accordance with our internal security policy and the law. More information can be found at www.dietitian-sydney.com/legalinfomation.

Office Policy:-
Please note that payment in full is required at time of consultation. Missed appointments or failure to provide 24 hours notice to reschedule or cancel an appointment will occur a cancellation fee of $**50**. I understand and agree to adhere to the Davis Dietetics office policy.

Signature:…… Date:……
(if under 18 years parents/guardian signature)

If you like our services please like us on google or facebook. A feedback form also available at www.davisdietetics.com/feedback .

Please turn over for health questionnaire

Health Questionnaire

What is Your Main Complaint?.....

Have you ever had any of the following?

Allergies □	High blood pressure □	Skin Problems □	Arthritis □
Sinuses □	Low blood pressure □	Eczema □	Epilepsy □
Asthma □	Osteoporosis □	High Cholesterol □	Chronic Fatigue Syndrome □
Anxiety □	Fluid retention □	Stroke □	Burning feet □
Depression □	Swollen legs □	Heart Disease □	Alcohol/drug Abuse □
Sleeping Problems □	Gall Stones □	Thyroid issues □	Cancer □
High Blood Glucose □	Shortage of Breath □	Bowel Disease □	Aneamia □
Diabetes □	Ulcers □	Bowel Polyps □	Migraines □

Do Any of the Following Bother You?

Headaches □	Indigestion □	Diarrhea □	Leg Cramps □
Dizziness □	Constipation □	Incontinence □	Back pain □
Anxiety □	Abdominal bloating □	Impotency □	Leg, Knees or foot pain □
Stress □	Abdominal pain □	Family problems □	Skin problems □
Coughing □	Nausea □	Fatigue □	Reflux □
Ulcers □	Vomiting □	Food sensitivities □	Cold sores □

Details:-……..……..

Are you on any medications/supplements? Please list:-

……..……

Has your weight been stable?.....

Do you have a family history of Diabetes □ Heart Disease □ High blood pressure □ High Cholesterol □

Do you smoke? Yes/ No/ Ex smoker