Client Registration Form

Any information you provide will be treated with complete confidentiality as per the Privacy Act 1988 (http://www.oaic.gov.au/privacy/privacyact/the-privacy-act).

1. CLIENT DETAILS *Please print clearly*

*Indicates compulsory field

*Mr / Mrs / Miss / Ms / Other	*Male / Female / Transgender / Intersex / Other	
*Surname	*Given Name	
*Preferred Name	*Date of Birth *(dd/mm/yyyy)*	
*Address		
*Suburb	*State	*Postcode
*Phone Number	*Or Mobile	
*Email		
Ethnicity	Occupation	

2. PRE-APPOINTMENT QUESTIONNAIRE

What is your main presenting condition/concerns?

BARIATRIC SPECIFIC (leave blank if you have NOT had Weight loss surgery)

Height:	**Current Weight:**
Have you had Bariatric Surgery? What Type? When?	
Presurgical Weight?	**Maintaining/ Gaining/ Losing/ Stalled ?**
Goal weight? By When?	
Did you have any complications as a result of your Surgery?	

What is your Current portion size? (how many cups of food per meal)

DO you know how many Calories _____| Carbs_____ | Proteins_____ | Fats_____ | you get per day?

Do you currently take prescribed Antacids ?

Any other relevant information pertaining to your weight loss surgery?

Do you have any children? If so, please list their ages:

Are you trying to conceive? ☐ Yes ☐ No Have you sought reproductive assistance? ☐ Yes ☐ No

If yes, for how long have you been actively trying?

ALLERGY

Do you have any known allergies (please list)?

Eggs ☐ Milk ☐ Wheat ☐ Shellfish ☐ Soy ☐ Mango ☐ Peanuts ☐ Strawberries ☐ Gluten ☐ Other ☐

If you **do** have allergies, please define what happens upon contact/ingestion:

Are you a smoker? ☐ Yes ☐ No Quantity / Day Are you seeking to stop smoking? ☐ Yes ☐ No

Do you Drink Alcohol? ☐ Yes ☐ No Quantity / Day/ Are you seeking to stop? ☐ Yes ☐ No

Have you had any previous fractures and/or surgeries? If yes, please list the body parts that were fractured and dates of injury (including car accidents / motor vehicle trauma). Please also list any past surgeries:

Have you had recurrent infections/ sinus or have had/have frequent antibiotic use?

Do you exercise? (Type and frequency)

Any known/ Diagnosed Vitamin/ Nutrient deficiency?

3. Current Medical Conditions

Describe your current Medical Conditions (Diabetes, Hypothyroid, Hashimotos, Auto-Immune, Fibromyalgia, PCOS etc) and health complaints (i.e. Wake in night to urinate, constipated, reflux etc) Do you now, or have you ever suffered from depression/anxiety or other mental health conditions? are you prone to stress ?

4. PAST AND CURRENT CONDITIONS

Please tick (√) all current or past conditions that apply to you (C - Current and / or P – Past).

Symptoms	C	P	Symptoms	C	P	Symptoms	C	P	Symptoms	C	P
Pain / Stiffness			**Digestive System**			**Skin**			**Other**		
Neck / Jaw			Diarrhoea			Rashes			Diabetes Mellitus		
Back			Gastric ulcers			Itching			Cancer		
Shoulder / Arm / Hand			Nausea / Anorexia			Wounds slow to heal			Hepatitis B / C		
Legs / feet			Constipation			Urticaria / Hives			HIV / AIDS		
At Night			Abdominal discomfort			Bruise easily			ADHD / Autism/ Asperger's		
In Morning			Indigestion			Dermatitis			**Women Only**		
Pins & Needles / Tingling			Reflux			Psoriasis			Difficult menstruation		
Arms / hands / fingers			GERD			Rash on back of arms			Hot legs prior/during menses		
Legs / feet / toes			H. Pylori			Darkened skin armpits			Yeast / Thrush		
Other			Bloating			Darkened skin thighs			Dark Clotting/ Heavy Loss		
Numbness			Difficulty digesting meat			Cystic Acne			PCOS		
Arms / hands / fingers			**Renal System**			Eczema			Breastfeeding		
Legs / feet / toes			Frequent urination			**Neurological System**			Menopause		
Other			Poor urine stream			Confusion			Low / Loss of libido		
Cold Extremities			Feeling of incomplete emptying			Memory loss			Premenstrual syndrome		
Hands			Urinary tract pain			Altered alertness			Painful intercourse		
Legs/feet			Incontinence			Changes in vision			Fertility problems		
Swelling			Interstitial cystitis			Muscle cramps			Hair growth / Excess		
Arms / hands			**Immune System**			Seizures			**Men Only**		
Legs / feet			Frequent colds / flu			Body fatigue			Prostate problems		
Puffy face / neck			Coeliac or Gluten intolerance			Tremor / Sway			Anger		
Other:			Anaphylaxis (bees etc)			Loss of balance			Excess Breast Tissue		

Balance			Frequent UTIs			General muscle weakness			Testicular pain			
Loss of balance			Chronic fatigue			Depression / Anxiety			Fertility problems			
Weakness / clumsiness			Hashimotos Thyroiditis			Stress			Central bloat/ Belly			
falls			Fibromyalgia			**Senses**			Low / Loss of libido			
Vertigo			Rheumatoid Arthritis			Headache			Hair loss			
Respiratory System			Cancer			Loss of taste			Dizziness / Light headed			
Difficulty breathing			IBD – Crohn's or UC			Heavy headed			Erectile dysfunction			
Cough			Multiple sclerosis			Fainting			**General Wellbeing**			
Sinus problems			Glandular fever			Sensitivity to smells			Fatigue			
Post Nasal Drip			Allergies			Chemical smell sensitivity			Tension			
Chronic cough			Multiple Antibiotic use.			Visual light sensitivity			Weight gain			
Hay fever			Autoimmune Disease			Visual impairment			Weight loss			
Morning Phlegm			Cold Sores/ Ulcers			Restless legs			unfit			
Wet cough			Warts			Phantom Pains			Low self esteem			
Asthma			**Heart & Circulatory**			Loss of Smell			Fog			
Chronic bronchitis			Heart problems / Angina			Loss of hearing			Irritability			
COPD			Pacemaker			Speech impairment			Nervousness			
Cystic Fibrosis			High blood pressure			Dry itchy eyes			Sleep problems			
Snoring			Low blood pressure			Tinnitus			Nightmares / Terrors			
Apneoa			Shortness of breath			**Other (add if not listed)**			Fevers			
			Varicose veins						White coating on tongue			
			Blood clots / DVT						Sweats			
			Stroke (CVA)						Ridging or spotting of nails			
									Hair loss			

For all items marked: Please give an explanation.

Please describe your average day in terms of energy level out of 10_ (0 being none - 10 being highly energetic) For the following times of day: a) Waking ____ b) 9:30-10:30am ____ c) NOON ____d) 2:00pm -3:00pm ____e) 7:00pm -9:00pm___ _ f) Bedtime.____
Do you Crave any specific foods? When?
Do you tire easily? find it hard to get going? Frequently feel irritated or anxious/stressed? Do you crave sugar or carbohydrate when you do? If no, what do you do to relieve these feelings?
Do you find any foods difficult to digest or tolerate? Please describe food and reactions.
What would a normal daily diet look like for you? i.e. breakfast, lunch, dinner, snacks, drinks, desserts, sweets etc. PLEASE list the types of foods (give examples) of what you eat for these meals.
Breakfast:
Lunch:
Dinner:
Snacks:

5. Exercise/ Fitness routine. (please outline your current fitness routine)

Exercise	Duration (mins)	Days per week

6. CURRENT MEDICATIONS / SUPPLEMENTS / HERBAL REMEDIES

Medication Name	Dosage (mcg/mg and # per day)	Duration of Medication	Related Condition

What are your own dietary goals and targets?
Any other issues that you would like to have addressed?

If you have had any recent or important bloodwork completed or any medical reports that you would like to supply with this questionnaire. Please send them via email as a pdf attachment.

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