Complete Chiropractic Care

CLINICAL NUTRITION
HEALTH QUESTIONNAIRE

Mr/Mrs/Ms/Miss/Mst: Surname:_____ First Name:_____

Occupation _____

Address _____ Suburb_____ P/C _____

Telephone (H)_____ (W) _____ (M) _____

Date of Birth _____ e-mail _____

Marital status _____ Partners' name _____

Name & Location of G.P _____

How did you find out about us? _____

Have you visited a clinical nutritionist before? Y/N_____

List the main problems you are experiencing or reasons for your appointment:

What do you believe the problem might be due to (if anything)?

What kind of treatments have you tried for the problems listed above?

Have you had any tests or investigations done for the problems listed above? Please list investigations completed, and bring copies of any test results to your consultation.

What **three** things would you most like to improve about your health over the next few weeks?

1. _____
2. _____
3. _____

What are your long term health goals?

_____

What is your biggest motivation for improving your health?

Have you ever suffered from any of the following? Please circle:

Asthma	Constipation/Diarrhoea	High Cholesterol	Abdominal Pain
Allergies	Bloating	Sinus Problems	Low blood sugar
Anxiety	PMS	Muscular pain	High blood sugar
Depression	Dizziness	Fatigue	Epilepsy
Digestive problems	Heart Problems	Hi blood pressure	Low blood pressure
Heart palpitations	Skin conditions	Weight loss	Migraines
Muscle Cramps	Weight gain	Chest pain	Reflux

Please list any other medical conditions or injuries;

Please list any medications or supplements (nutritional/herbal) you are taking.

Do you have any allergies or intolerances? Please list known allergies and intolerances:

Please list any chronic or significant conditions relevant to your family members:

Father	Mother	Siblings
Paternal Grandparents	Maternal Grandparents	Children
Paternal Uncles/Aunts	Maternal Uncles/Aunts	Partner

How much do you usually sleep per day? Do you have any problems with sleep?

Please rate your energy on a scale of 0-10 at each point in the day:

Mornings: _____ Afternoons: _____ Evenings: _____

Please provide a 2 day sample of what you eat and drink on a daily basis:

Day 1		Day 2	
Morning:		Morning:	
Mid-Morning:		Mid-Morning:	
Midday:		Midday:	
Afternoon:		Afternoon:	
Evening:		Evening:	
Late Evening:		Late Evening:	
Beverages:		Beverages:	
Water:		Water:	
Tea/Coffee:		Tea/Coffee:	
Alcohol:		Alcohol:	

What oils do you typically use for your food preparation? (e.g. Butter, margarine, canola oil, sunflower oil, olive oil)

Is there any food you tend to crave?

Is there any food you particularly dislike?

How many times a week/month do you eat take away meals? What type?

How do you feel if you skip a meal? (e.g. tired, irritable, normal etc.)

How do you feel after a meal? (e.g. Full of energy, tired, sleepy, normal etc.)

Informed Consent for Nutritional Medicine Treatment and Care

I hereby request and consent to the performance of nutritional medicine treatments on me (or the patient named below, for whom I am legally responsible) by the clinical nutritionist named below and/or other accredited practitioners who now or in the future treat me while working or associated with the practitioner named below, whether signatories to this form or not.

The natural foods and supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of nutritional medicine, although some may be toxic in large doses. I understand therefore that recommended foods and supplements need to be consumed according to the instructions provided orally and in writing. I understand that some foods and supplements may have an unpleasant taste or smell. I will immediately notify the practitioner of any unanticipated or unpleasant effects associated with taking these foods and supplements.

I do not expect the practitioner to be able to anticipate and explain every possible risk and complication of treatment, and I wish to rely on the practitioner to exercise their professional judgment during the course of treatment and to act based upon the facts then known towards my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment form have been told about the risks and benefits of nutritional medicine and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Are you pregnant? Yes/No **If yes how many weeks? _____**

_____ _____

Patients Signature Print Name of Patient

(Parent or Guardian to sign if patient is under 18)

_____ _____

Gina Long Date

Clinical Nutritionist