Initial consultation questionnaire

NUTRITIONAL
MATTERS

title _____ surname _____ given name(s) _____

sex: m ☐ f ☐ age _____ date of birth _____

address _____

city _____ postcode _____

phone (m) _____ phone (h) _____

email _____ occupation _____

relationship status: single ☐ in a relationship ☐ married or de facto ☐ number of children ☐

emergency contact name _____ phone _____

height _____ weight _____ Have you seen a Nutritionist before? yes ☐ no ☐

Where did you hear about Nutritional Matters / Angela?

Google ☐ Facebook ☐ Friend ☐ Natural Therapies Pages ☐ other _____

What is your key reason for seeing a Nutritionist?

_____

_____

What areas of your health do you wish to improve, in order of priority?

1: _____

2: _____

3: _____

List any operations or traumas (physical or emotional) you have had in the past two years.

_____

_____

Please tick any of the below that apply to you.

vegan ☐ vegetarian ☐ lactose intolerant ☐ gluten intolerant ☐ other _____

Do you have any allergies? yes ☐ no ☐ If yes, please state _____

Are these allergies life-threatening? yes ☐ no ☐

Do you exercise? yes ☐ no ☐ If yes, what activity _____

How often _____ How long is each session _____

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Initial consultation questionnaire continued

Family history: Please mark "**S**" for self, "**F**" for family member or "**B**" for both if you have now or have had in the past any of the following:

- ☐ Acne / eczema / psoriasis
- ☐ Allergies / Asthma
- ☐ Arthritis
- ☐ Anxiety / depression
- ☐ Cancer
- ☐ Cardiovascular diseases (high blood pressure)
- ☐ Diabetes Type 1 or Type 2
- ☐ Digestive disorders
- ☐ Immune dysfunction
- ☐ Kidney stones
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Reproductive problems
- ☐ Migraines / headaches
- ☐ Thyroid problems
- ☐ Other

List any medications or vitamins you are currently taking

Medication/vitamin	Brand	Dosage	Reason	Has this helped?

Would you like to receive Nutritional Matters communication, via email eg health newsletters & clinic updates?
Please tick box ☐ (you will be able to unsubscribe at any time)

Informed Consent and Privacy

I (print name)_____ declare all answers and statements contained in this Initial Consultation Questionnaire are true and complete. I understand that a nutritionist does not diagnose illness, disease or any other mental or physical disorder and does not prescribe medical treatment. I understand that my nutritionist is not a substitute for medical diagnosis and treatment. I understand that it is important for my nutritionist to be aware of all past and present medical conditions, as well as any additions or changes to supplements and medications. I will ensure that I will inform my nutritionist of any changes to the information I have provided. All information shared within the professional relationship will be held with the strictest confidence. Information may only be shared with a medical doctor, or other healthcare practitioner upon the consent of the client.

Signature _____ Date / /