Francesca Eldridge Health / Registered Clinical Nutritionist

NEW CLIENT FORM

Date:_____________________ Name:_______________________________________

Address:____

Phone:______________________________ Email:___________________________

D/O/B:____________________ Age:___________ Gender:______________________

Relationship status (teens and adults):_______________________________________

Occupation or past occupations:____

Emergency contact person (name, number, relation to you):_____________________

____

Are there any religious, cultural or other considerations I need to be aware of?

____

CLIENT CONSENT

I,____give consent for my health information to be documented and physical examinations performed. I understand that a treatment plan will be created for me by the practitioner (Francesca Eldridge). I have given the practitioner all personal information needed to perform a safe and successful treatment, including disclosing all medications I am taking and whether I have recently become pregnant or intend to do so soon.

I am aware that both myself and the practitioner have the right to stop treatment at any time. I agree to disclose to the practitioner if I have an adverse response to any of the recommendations in my treatment plan. I understand that the practitioner is not providing medical care and is providing advice around diet, lifestyle and relevant diagnostic testing.

I have read and sign my agreement to the Terms and Conditions listed at the bottom of this web page: www.francescaeldridgehealth.com/bookings.html

Signature:_______________________________________Date: __________________

Practitioner name and signature:____

Your health concerns and goals

Please describe your health concerns:____

When did they start?____

What was happening around or just before the onset of your symptoms?___________

____

What do you feel are contributing causes?____________________________________

____

Have you noticed if anything worsens or reduces your symptoms? (foods eaten, stress levels, caffeine, being around or not around certain people or environments?)

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____

What are your medium-term health goals? And long term? ______________________

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____

How strong is your motivation to make long-term changes to your diet and lifestyle for your health? What challenges might you have to overcome in making changes?

____

____

History

Were you a vaginal or caesarean birth?

____

Were you breastfed? For how long?____

Any injuries, accidents, hospitalizations or surgeries before age 19?

____

Any accidents, injuries, hospitalizations or surgeries from age 20 onwards?

____

____

Any history of skin problems, seasonal allergies or asthma?______________________

____

Have you travelled abroad – where and when?_________________________________

____

Please list all past and current prescription medication use, including when taken, for how long and dosage? Please include all courses of antibiotics.

____

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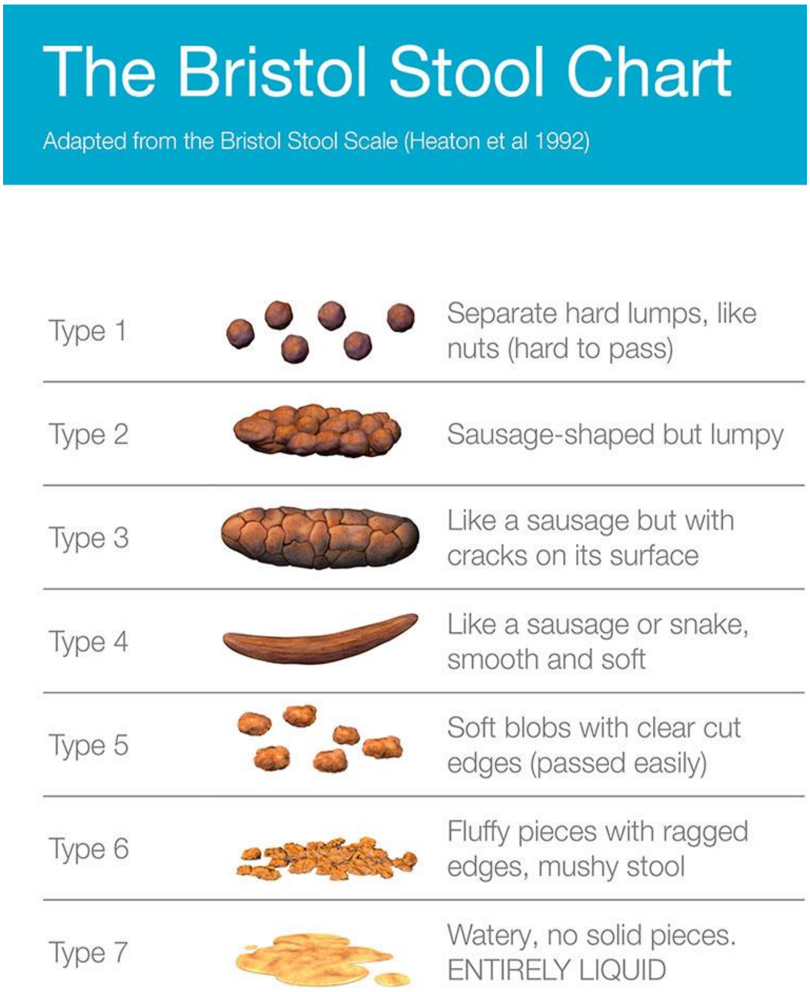
Have you received any vaccinations?____

Do you have dental fillings? Which type?______________________________________

Eliminations

Please tick the type of stools you normally pass and state colour and frequency (e.g., dark brown / light brown / orange / green >> every morning, five times a day, every second day)



Poo notes:____

____

Urine – how many times per day and colour?________________________________

Any urinary urgency or incontinence?______________________________________

Sweat – at rest or when active? Noticeable smell?____________________________

Periods – how often, heavy or clotty, any PMS (cramps, tender breasts, water retention, headaches, migraines, acne….anything else?) Please include any mental health PMS experiences such as increased anxiety, increased crying, suicidal feelings or feelings of deep sadness.

____

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____

____

Lifestyle, sleep and energy levels

Describe your alcohol consumption–how many drinks per week and which type?

____

Do you smoke cigarettes? How many per day/week?

____

Do you take recreational drugs (now or in the past)? Which drugs and how often? Please mention if you mix tabaco with any marijuana smoked. Please note, there is no judgment from me and information you provide remains strictly confidential.

____

____

Which brands of soap, shampoo, cosmetics, skin products and deodorant do you use on your body most days?

____

Do you fall asleep easily?

How many hours a night do you normally sleep?

Ever wake during the night? Please describe (timing, frequency)

Do you remember your dreams? (often, sometimes, never?)

Preferred exercise and frequency?____

Do you ever:

-wake feeling tired? Y / N (please describe)

-have energy crashes? Y / N (please describe)

-feel wired, and what time of day does this usually occur?

Emotional health

Have you experienced trauma (abuse, neglect, highly distressing events) as a child, teen or adult?

What causes stress in your daily life?

Do you have people you feel safe discussing your feelings with, who you can rely on for emotional support and a listening ear?

Family health

Please briefly note any health conditions experienced by your:

-mother

-father

-siblings

-mother's parents

-father's parents

Thank you for taking the time to complete your new client form, this helps us maximize the time available for your first appointment.

All information you have provided will remain strictly confidential.