Client registration form

Welcome to Create Wellbeing Group. Please answer the following questions as accurately as possible. Any information you provide will be held strictly confidential.

When completed, email to Nicole McAuliffe at Nicole@createwellbeinggroup.com or fill it out by hand and mail/email or text to Create Wellbeing Group PO Box 58, Kew East, VIC 3102

CONTACT DETAILS

Date:_____ Name:_____

Birth date: _____ Age: _____ Sex: female male

Address: _____

Contact numbers: home: _____mobile:_____

E-mail: _____

Emergency contact: name: _____relationship: _____ phone: _____

Health practitioner/doctor: name: _____phone: _____

Referral information: name/type:_____

Have you seen a nutritionist before?: Yes/No

MEDICAL HISTORY

1. Do you take any prescribed or over-the-counter medication on a permanent or semi-permanent basis? Yes /No

   If yes, please list: _____

2. Are you allergic to any medication? Yes /No

   If yes, please list: _____

3. Do you have any injuries that are not completely healed? Yes /No

   If yes, please explain:_____

4. Do you currently have any pain in any part of your body? Yes /No

   If yes, please explain:_____

5. Have you had any fractures or surgical procedures? Yes /No

   Describe (include date(s): _____

7. Date of your last doctors visit / examination:_____

8. Do you now or have you ever experienced any of the following? Put an X next to all that apply:

Chest Pains	Daily Coughing
Chest Pressure	Fainting
Heart Palpitations/Skipping Beats	Seizures
Unexplained weight change	Difficulty walking
Dizziness	Allergies
Stumbling	Numbness
Headaches/migraines	Shortness of breath
Other	

9. Do you have or did a physician ever diagnose you as having any of the following?

Heart Disease/Condition	Diabetes
Thyroid disease	Emphysema
Asthma	Autoimmune disease
Circulatory Problems	Chronic Bronchitis
Anemia	Epilepsy
Kidney Disease	Liver Disease
High or Low Blood Pressure	Neurological Problems
High Cholesterol	Arthritis
Osteoporosis	Cancer
Coeliac disease	Other

10. Are you presently under a physician's care for any of the above or for any other condition? Yes/No
11. Do you have a family history of any of the above diseases Yes/No
    If yes, please explain?_____
12. Have you had any other major illnesses? Yes/No
    If yes, please explain: _____
13. Have you or do you smoke?
    How many packs/cigarettes per day? _____for how many years?_____
14. Do you drink alcohol? Yes No
    If yes, how often do you drink? (# days per week) _____How much do you consume?_____
15. What is your occupation? _____
16. On a scale from 1-10 (10 being very high), how would you rate your stress level?
17. How many hours of sleep do you average? On a week night? _____ On a weekend night? _____
18. How many hours of private "down time" do you have per weekday? _____ On the weekends? _____
19. Do you generally feel rested? Yes/No Rate your energy level between 1-10: _____
20. Rate your general health: excellent good fair poor
21. Rate your level of physical fitness: excellent good fair poor

FOR WOMEN ONLY

22. Do you menstruate regularly? Yes/No
23. Do you have children? Yes/No If yes, how many, what are their ages? _____
24. Are you pregnant? Yes/No If yes, approximate due date?_____Any prior miscarriages?:_____
25. Have you gone through menopause? Yes/No If yes, when? _____

CURRENT NUTRITION INFORMATION

Describe in detail the food/beverages and supplements consumed over a typical 3 day period (ideally one weekend and two weekdays). Include all brand names and portion sizes to the best of your ability. Detail all ingredients in home-prepared dishes and list restaurant names and menu items when dining out. Please indicate your hunger level before and satiation level after all meals and snacks. Finally, describe where you were eating, what, if anything you were doing while eating (i.e. reading, watching TV), and who, if anyone, you ate with.

Meal & Time	Day One	Day Two	Day Three
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			
Supplements			

26. Do you have any food allergies or intolerances? Yes /No If yes, what are they? _____

27. Do you have any aversions to any foods? Yes/No If yes, what are they?_____

28. Are there any other foods you avoid for any other reasons? Yes /No If yes, what are they? _____

29. What are your 5 favorite foods? _____

30. Do you have any "trigger" foods (foods you have trouble exercising portion control)? _____

31. Do you like to cook? Yes/No

32. Do you eat regular meals? Yes /No

33. How often do you eat fast food? (# days per week)_____

34. Do you drink coffee or tea? Yes /No If yes, how many cups per day?_____

EXERCISE HISTORY

35. What is your height?_____

36. Current weight? _____ Do you weigh yourself everyday? Yes/No

37. Lowest weight past 12 months? _____kg

38. Goal weight? _____ When were you last at that weight?_____

Record your exercise history including ALL sports/physical activities beginning with most experienced.

Sport /Physical Activity	Years of Experience	Experience Level (school level, professional etc.)

Current weekly exercise routine over the past week. Record approximate volume or time into each cell

Type	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday