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Congratulations!

Today is the beginning of making YOUR health a priority!

At Inner Fit Nutrition we strive to help to achieve your health and wellness goals, providing support and resources to get you on the right track.

Please see attached initial intake forms and 3 day food diary for you to fill in ***prior*** to your appointment.

Please fill this out to the best of your knowledge and be honest with the food diary. This gives me an idea of what you are currently eating and where support is required. If you can make one of these days over the weekend that too would be great, but they don't need to be consecutive days.

Appointments go for 75-90 minutes. Initial consults are $150. Within a week of your initial appointment, I will present to you a thorough report of findings detailing dietary, lifestyle and if any, supplementation recommendations. (30 mins $40). Specific meal planning is an additional $49 if required.

If you have private health insurance and nutrition selected on your cover, you may be eligible for a rebate from you fund.

PLEASE MAKE A NOTE OF THE LOCATION OF YOUR APPOINTMENT WHEN MAKING YOUR BOOKING

Cancellation policy- A cancellation fee of $50 is charged for any consult that is cancelled within 24hrs of the appointment time.

Regards

Amanda Martindale

Clinical Nutritionist

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CLIENT INITIAL ASSESSMENT INFORMATION FORM

PERSONAL INFORMATION

NAME…… DOB-……

ADDRESS-……

……

PHONE- …… EMAIL……

IF UNDER 18 YRS OF AGE, NAME OF PARENT / GUARDIAN……..

EMERGENCY CONTACT NAME……CONTACT NUMBER……

PRIVATE HEALTH Yes No (Please Circle) FUND NAME……..

MEDICAL AND HEALTH HISTORY

Current Weight…… Height ……

Are you currently taking any medications (supplements, over the counter or prescribed)? Please detail below as much information as possible

MEDICATION	DOSE PER DAY	MEDICATION	DOSE PER DAY

Is there any significant family history of illness and/or disease? Please specify.

……

……

Do you have any allergies, food intolerances or sensitivities? Please indicate below.

FOOD SOURCE	YES	FOOD SOURCE	YES	FOOD SOURCE	YES
Dairy		Tomatoes		Flavours	
Nuts		Citrus fruits		Amines	
Gluten		Eggs		Salicylates	
Wheat		Garlic		Other: Please specify	
Yeast		Onion			
Fish		Preservatives			
Shellfish		Colours			

Please select any of the following conditions that may be relevant to you, and make any specific comments. If inapplicable please mark NA.

SYMPTOM	YES	COMMENTS
Bloating		
Heartburn		
Constipation		
Diarrhoea		
Undigested Food in stools		
Intestinal Worms / Parasites		
Angina		
High Blood Pressure		
Low Blood Pressure		
High Cholesterol		
Dry skin		
Dandruff		
Eczema		
Ringworm		
Dermatitis		
Oily skin		
Acne		
Psoriasis		
White spots on nails		
Flaky, brittle nails		
Hair Loss		
Heavy menstrual periods		
Irregular menstrual periods		
Short periods (less than 25 days)		
Long periods (more than 33 days)		
Pre-menstrual Symptoms (PMT)		
Low libido		
Thrush or STI's / STD's		
Erectile dysfunction		
Memory loss		
Night sweats		
Cold hands and feet		
Brain fog / vague		
Anxiety		
Depression		
Muscle pain and / or spasms		
Dizziness		
Migraines		
Hayfever		
Allergies		
UTI's (recurrent)		
Recurrent colds and flus		
Asthma		

LIFESTYLE INFORMATION

What is your occupation?-…….

Do you work?

☐ Part time ☐ Fulltime ☐ Casual

What is the activity level of your job?

☐ None (seated) ☐ Moderate (lightly active such as walking) ☐ High (heavy labour)

Does your job involve shift work?

☐ Yes ☐ No

Are you currently undertaking any form of activity or sports? ☐ Yes ☐ No

If yes please give details- (type and number of times per week inc. training)

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……

How would you describe your lifestyle in terms of health?

☐ Unhealthy ☐ Room for improvement ☐ Relatively healthy ☐ Very healthy

Give a score for your energy levels throughout a normal day.

☐ 1 ☐ 2 ☐ 3 ☐ 4

Lethargic……Energised

Do you smoke?

☐ Yes ☐ No ☐ Ex -smoker If yes, how many per day?……

Do you drink alcohol?

☐ Yes ☐ No If yes, how many per week?……

Do you entertain with friends and family often? If so, how many times per month?

……

……

How do you rate your stress levels?

☐ 1 ☐ 2 ☐ 3 ☐ 4

Relaxed……Stressed

CURRENT NUTRITIONAL STATE

How much water do you drink on average per day? (glasses?).....

Do you drink coffee or tea? If so, how much?

.....

How many meals do you eat per day? (include snacks such as morning and afternoon tea)

☐ 1-3 ☐ 3-5 ☐ 5-7 ☐ 7-9

Do you generally take your lunch and snacks to work with you or do you buy it? If you buy it, how many times per week?

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Please list any foods that you don't enjoy eating

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Please list foods that you do like to eat

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PERSONAL GOALS

What short term goals would you like to achieve with this nutritional advice?

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What long term goals do you aspire to achieve?

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.....

Are there any reasons why you think you may not achieve your goals? (ie time restricted, no support network, laziness, work commitments, injury, cost etc.)

.....

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OTHER INFORMATION

Is there anything else that you think will assist in preparing your nutrition program? Please specify

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Consent - I hereby agree and understand that the treatment/advice given will include one or more of the following; dietary prescription, lifestyle prescription, nutritional/herbal supplements and screening tests, which I knowingly and willingly consent to undergo of my own free will. At any time I may reject any treatment or advice without prejudice from the practitioner. I understand that nutritional/herbal supplements are prescribed in a therapeutic fashion and if circumstances change (e.g. pregnancy, cessation/commencement of pharmaceutical drugs etc) from what was presented to the practitioner, I will notify the practitioner immediately, so treatment/advice can alter accordingly if required. I understand that contact details may be used to enable correspondence via email.

Name…….

Signed …….. Date……

	Day 1	Day 2	Day 3
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			
Water (Glasses)			
Other Drinks			