

Welcome to Body & Brain Centre!

Name: _____ DOB: _____ Age: _____

Address: _____ Suburb: _____ Postcode: _____

Phone: _____ Mobile: _____ Occupation: _____

Email Address: _____ Hobbies: _____

Please Tick: I would like to receive newsletters with special offers, health tips and more.

Marital Status: _____ Partner's Name: _____

Children Names & Ages: _____

Could you be pregnant? No Trying Yes: ____ weeks Are you breastfeeding? Yes No

Who can we thank for referring you? _____ PS they will get a thank-you voucher

If online, what search words were used? _____

Have you seen a dietitian before? Yes / No Last treatment: _____

Name of previous dietitian: _____

What's the purpose of your visit? _____

What do you feel are the main factors impacting on your health right now?

What general goals would you benefit from working on: _____

How often do you exercise? Daily Every second day Weekly Rarely

At what intensity do you exercise? Low Medium High

Allergies / Sensitivities: _____

How would you rate your appetite? Excellent Good Not bad Poor

Have you been on a diet in the past 12 months? Yes (please specify) No

What is the range of your Blood Glucose Levels (only if relevant)? _____ mmol

Who does the shopping? Self Partner Parents Other _____

Who does the cooking? Self Partner Parents Other _____

Please list any medication (including supplements, contraception & recreational drugs):

Current: _____

Significant Previous: _____

Have you ever smoked? Current Past Never How long? _____ How many daily? _____

Have you consume alcohol? Yes No If yes, how often? _____

Do you suffer from any gastro symptoms or discomfort? Yes No

If yes, what are they and how often does it occur? _____

Physical

Chiropractic
Myotherapy
Remedial Massage

Brain

Biofeedback
Neuro-Rehab
Brain Scans

Emotional

Counselling
Meditation

Nutritional

Dietetics/Nutrition
Naturopathy

Traditional

Acupuncture
Chinese Medicine

What is your usual daily food intake. Please be detailed, including time of day.

	Food	Drink
Breakfast Time: _____		
Morning Tea Time: _____		
Lunch Time: _____		
Afternoon Tea Time: _____		
Dinner Time: _____		
Other Time: _____		

Medical history: Have you suffered any major or recurring conditions?

Family history: Has someone in your Family suffered any major or recurring conditions?

What issues do you want to address with the dietitian? _____

Any other information? _____

Informed Consent to Dietetics / Nutritional Care

- 1. Physical Examination:** Your dietitian may perform a physical examination, such as measurements. This will rarely provoke slight discomfort.
- 2. Nutritional Advice and / or supplements:** Majority of the time, people feel better, however on occasions some individuals may experience gastrointestinal discomfort or disturbances (constipation, diarrhoea), skin rash and potential for drug interactions.

Other treatment options include medication or surgery which also carry risks such as organ irritation, dependence to medication, infection and extended recovery times. **Delaying or remaining untreated** can complicate your condition making future treatment more complex.

Research studies and presentations are performed from time to time within Body and Brain Centre (BBC). All identifying information is removed. Participation is voluntary and consent may be revoked at any time. There are no additional risks associated with helping us educate future practitioners and the public.

I have read the above and acknowledge I am aware of and understand the potential risks. I understand that whilst results are not guaranteed, my dietitian has my best interests at heart.

Please Tick

- The information provided is accurate and fully inclusive to the best of my knowledge.
- I hereby request and consent to dietetic examination and management.
- I hereby consent for my de-identified information to be used in research and presentations at BBC.
- I consent to information being sent to third parties when I have authorised it (eg: private health insurance)
- I understand I must provide 24 hours notice if I'm unable to attend my scheduled appointment to avoid paying a 50% cancellation fee. I also understand that fees are payable on the day of consultation.

SIGNATURE _____

DATE _____

PRINT NAME _____
(Parent/Guardian if under 18 years)

DIETITIAN'S SIGNATURE _____
Own behalf of any current or future dietitian of BBC

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