THE SPROUT NUTRITION & WELLNESS

Every great thing starts from something small

CLIENT REGISTRATION & INITIAL INTAKE FORM

Welcome to the start of your experience with The Sprout Nutrition & Wellness. This is the first step of your journey with us, where we find out a bit about you and your history so your appointment time can be maximised getting into the nitty gritty. We recommend making yourself a cuppa and finding a comfy spot to complete this form, which will take around 30-45 minutes.

Please bring a completed copy of all pages of this form with you to your appointment and/or email to hello@thesprout.com.au

Any information you provide will be treated with complete confidentiality as per the Privacy Act 1988. Personal information will only be collected for purposes directly related to your healthcare or a function or activity of The Sprout Nutrition & Wellness to provide its service to you. The Sprout Nutrition & Wellness is a judgement-free zone where we encourage you to be as open as you feel comfortable to best manage and tailor your treatment.

THE BORING [BUT NECESSARY] BITS

THE BASICS	
Title (Mr, Miss, Ms, Mrs, Dr):	**Gender:**
Surname:	**Given name/s:**
Preferred name:	**Occupation:**
Date of Birth (dd/mm/yyyy):	**Ethnicity:**
Address:	
Email address:	
Phone:	**Mobile:**
Private health insurance provider (if applicable):	
PRIMARY HEALTHCARE PROVIDER/DOCTOR	
Practitioner name:	**Phone:**
Practice name:	
EMERGENCY CONTACT	
Name:	**Phone:**
Address:	
Relationship to you:	

I understand The Sprout Nutrition & Wellness keeps all information fully confidential unless my life is in immediate danger. I understand that I am responsible for providing information upon registration and in consultation that is, to the best of my knowledge, accurate in order for my practitioner to make sound decisions regarding my treatment.

Signature: …… **Date:** / /

Ph: +61 424 955 265 **Email:** hello@thesprout.com.au **Web:** www.thesprout.com.au

THE SPROUT NUTRITION & WELLNESS

Every great thing starts from something small

YOUR CURRENT HEALTH

PRIMARY CONCERN/S

Please tell us why you've chosen to see a clinical nutritionist

OTHER PRACTITIONERS

In the past 12 months, have you seen any other complementary or allied health practitioners? Please specify. (eg, physio, chiropractor, acupuncturist, TCM doctor, naturopath, homeopath, kinesiologist, counsellor, psychologist, life coach etc)

ALLERGIES & INTOLERANCES

Do you have any known allergies and/or intolerances?

MEDICATION & SUPPLEMENTATION

Please list current medications and/or supplements you take (including contraceptives, paracetamol, ibuprofen, antacids and aspirin)

Name of product	Dosage	When do you take this?	How long have you been taking this?	Reason for taking	Does it help? (no, slightly, moderately, completely)

Ph: +61 424 955 265 **Email:** hello@thesprout.com.au **Web:** www.thesprout.com.au

THE SPROUT NUTRITION & WELLNESS

Every great thing starts from something small

YOUR HEALTH HISTORY

YOUR BIRTH & INFANCY (IF KNOWN)	
Vaginal or Caesar?	Breast or formula fed?
Full-term, late or premature?	Fully vaccinated?

PATHOLOGY
When was your last blood test and what did it cover? Was anything abnormal? You are strongly encouraged to bring a copy of your pathology results to your consultation if you have them.

MEDICAL HISTORY
Please give details of any occasion/s where you have been hospitalised (when, what for & for how long)
Please list any medical condition/s you have been diagnosed with and when you were diagnosed
Did you need multiple courses of antibiotics before you were two years old?
Have you frequently needed to take antibiotics orally (eg, for recurrent infections)?
Have you ever had to take antibiotics for more than two weeks?
Have you ever taken prolonged courses of steroids?

FAMILY HISTORY

Please mark with an X any relevant conditions your blood relatives have been diagnosed with. For multiple relatives, use one X per person (ie, if both your mother and grandmother have/had a condition, mark with XX)

Condition	Relative/s	Condition	Relative/s	Condition	Relative/s
ADD/ADHD		Depression		Migraines	
Alzheimer's disease		Early-onset dementia		Multiple Sclerosis	
Anxiety		Epilepsy		Neural tube defects	
Autism spectrum		Fibromyalgia		Polycystic ovaries or PCOS	
B12/folate anaemia		Grave's disease		Psoriasis	
Bipolar disorder		Haemochromatosis		Reflux (GERD)	
Cancer		Hashimoto's		Rheumatoid arthritis	
Cardiovascular disease		Hepatitis (A/B/C)		Schizophrenia	
Chronic Fatigue Syndrome		High blood pressure		Systemic lupus	
Crohn's disease		HIV/AIDS		Ulcerative colitis	
Diabetes – type 1		Hypothyroidism			
Diabetes – type 2		Low blood pressure			
OTHERS:					

Ph: +61 424 955 265 **Email:** hello@thesprout.com.au **Web:** www.thesprout.com.au

YOUR LIFESTYLE

DRUGS & ALCOHOL	
Are you a current smoker?	Do you use recreational drugs?
If yes, how many cigarettes/cigars per day?	If yes, please specify type, form & frequency.
If no, have you smoked in the past?	
Do you drink alcohol?	Have you ever struggled with substance abuse?
If yes, what and how often?	If yes, which substance/s?
HOBBIES, OCCUPATION & RELATIONSHIPS	
Occupation:	Hobbies:
Hours/week:	
Are you in a relationship?	Are there activities you would like to do, but don't do currently?
If yes, are you happy in your relationship?	
Do you have a child/children?	How often do you feel stressed?
If yes, how old?	What causes you stress?
PHYSICAL ACTIVITY	
Do you exercise?	
If yes, what activities?	
How often?	
How long has this been part of your lifestyle?	
Do you recover quickly?	
If no, how long does it take to recover and what symptoms do you experience?	
DIET	
Do you follow a particular diet or have rules about what you can/can't eat?	
Do you have dietary preferences (eg, Halal, vegetarian etc) based on personal choice and/or religious beliefs?	
Are there any foods you feel 'disagree' with you?	
Do you get cravings?	
If yes, what for and how often?	
How much water do you drink per day?	Do you drink juice, soft drink or energy drinks?
Is it filtered, tap, sparkling?	If yes, please specify what, how much and how often.
Do you drink tea and/or coffee?	
Please specify type and quantity/day.	

THE FOLLOWING PAGE IS A FOOD JOURNAL TO CAPTURE A TYPICAL WEEKDAY AND WEEKEND DAY OF EATING. PLEASE WRITE DOWN YOUR ACTUAL INTAKE – NOT WHAT YOU THINK YOUR NUTRITIONIST WANTS TO SEE. YOU CAN BASE THIS OFF WHAT YOU ATE AND DRANK YESTERDAY, OR WHAT AN AVERAGE DAY FOR YOU LOOKS LIKE.

Ph: +61 424 955 265 **Email:** hello@thesprout.com.au **Web:** www.thesprout.com.au

THE SPROUT
NUTRITION & WELLNESS

Every great thing starts from something small

WEEKDAY			WEEKEND DAY		
TIME	FOOD/DRINK	QUANTITY	TIME	FOOD/DRINK	QUANTITY

Ph: +61 424 955 265 **Email:** hello@thesprout.com.au **Web:** www.thesprout.com.au

THE SPROUT NUTRITION & WELLNESS

Every great thing starts from something small

BODY SIGNS & SYMPTOMS

For the following section, please mark anything that applies to you with an X.
P = Previously, C = Currently

GASTROINTESTINAL/DIGESTION	P	C	IMMUNE	P	C
Sensitivity to odours (petrol, perfume, bleach etc)			Frequent colds/flu		
Sensitivity to alcohol or caffeine			Glandular fever		
Sensitive/adverse reactions to medications			Ongoing sore throat		
Frequent nausea or vomiting			Neck, armpit and/or groin swelling		
Rarely hungry			Epstein-Barr virus		
Always hungry			Frequent sinusitis or nasal congestion		
Gallstones			Post-nasal drip (mucus drips down back of throat)		
Gallbladder removed			Slow wound healing (incl. oral ulcers)		
Constipation			Recurring infections (ear, UTI, tonsillitis etc)		
Diarrhea			Allergies		
Loose stools and/or nausea after high-fat foods (eg, cream, fast foods, avocado)			Cold sores		
Sense of incomplete defecation			Autoimmune condition/s		
Blood in stool			**INTEGUMENTARY**		
Mucus in stool			Ingrown hairs		
Undigested food in stool			Acne or frequent breakouts		
Foul-smelling stools			Eczema		
Pale clay-coloured / black / yellow stools			Dermatitis		
Pain while defecating			Psoriasis		
Sense of bowel urgency			Melanoma		
Upper abdominal bloating			Hives		
Lower abdominal bloating			Flaky/scaly skin		
Abdominal audible ‘gurgling’			Brittle or peeling nails		
Abdominal pain or discomfort			Ridged nails		
Excessive or foul-smelling flatulence			White spots on nails		
Excessive burping			Nail biter		
Bad breath			Dry nail beds/cuticles or hang nails		
Reflux (GERD)			Cracked or peeling heels or fingertips		
Heartburn			Chapped lips		
Unexplained weight loss			Cracked corners of lips		
Struggle to gain weight			Dry mouth and/or nose		
Peptic ulcers			Itchy eyes		
Anorexia			Dry eyes		
Bulimia			Dandruff		
Binge eating			Oily hair		
H.pylori infection			Brittle hair		
Gastric surgery (sleeve, bypass, band, section of intestines removed)			Hair loss		
Thick tongue coating			Excessive or hard ear wax		
Itchy anal/rectal area			Blue tinge to whites of eyes		
Diverticulitis			Yellow tinge to whites of eyes		
Appendicitis			Warts		
Amalgam (‘silver’) dental fillings			Tinea/fungal infections		

Ph: +61 424 955 265 **Email:** hello@thesprout.com.au **Web:** www.thesprout.com.au

THE SPROUT NUTRITION & WELLNESS

Every great thing starts from something small

For the following section, please mark anything that applies to you with an X.
P = Previously, C = Currently

RESPIRATORY	P	C
Asthma		
Chronic cough		
Frequent bronchitis		
Wheezing		
Pneumonia		
Burning sensation of lungs		
Hay fever		
CARDIOVASCULAR		
Chest pain / angina		
High blood pressure		
Low blood pressure		
Elevated heart rate		
Varicose veins		
Frequent/easy bruising		
Frequent yawning		
Anaemia		
Pacemaker		
Arrhythmia		
Blood clots/DVT		
Stroke		
Excessive fatigue		
Shortness of breath		
Dizziness		
Nosebleeds		
Heart palpitations		
High cholesterol		
Swelling in feet, ankles or legs		
Numbness/tingling in hands/feet		
Difficulty concentrating/poor memory		
SLEEP		
Insomnia		
Night terrors		
Vivid dreams		
Night sweats		
Restless legs		
Muscle cramping		
Snoring		
Sleep apnoea		
Headache on waking		
Consistently less than 7 hours' sleep		
Waking during the night		

MUSCULOSKELETAL	P	C
Arthritis		
Joint pain		
Joint stiffness		
Osteoporosis		
Muscle aches/pains		
Muscle cramping		
Body points tender to touch		
Muscle twitch or tremble		
Muscle loss/wasting		
Feelings of muscle weakness		
Limited range of motion/impaired mobility		
RENAL/URINARY		
Frequent urination		
Dark urine		
Cloudy urine		
Frothy urine		
Pain on urination		
Poor urine stream		
Feeling of incomplete urination		
Incontinence		
Strongly-odoured urine		
Blood in urine		
Kidney stones		
Recurrent urinary tract infections		
ADRENALS		
Extreme overwhelm		
Extreme stress		
Mood swings		
Hard to get up in the morning		
Need coffee/tea/chocolate/tobacco as a 'pick me up'		
Difficulty staying awake/alert during day		
Extreme irritability		
Get a 'second wind' at night		
NEUROLOGICAL & NERVOUS		
Clumsy		
Impaired sense/s		
Seizures		
Confusion		
Memory loss		
Headache		
Fainting		
Trembling hands		
Pins & needles in limbs		
Poor coordination		
Unsteady on feet		

Ph: +61 424 955 265 **Email:** hello@thesprout.com.au **Web:** www.thesprout.com.au

THE SPROUT NUTRITION & WELLNESS

Every great thing starts from something small

For the following section, please mark anything that applies to you with an X.
P = Previously, C = Currently

NEUROLOGICAL & NERVOUS (CONT'D)	P	C	***LADIES ONLY****	P	C
Changes to vision			Menopause		
Photosensitivity			Period started before 12 years old		
Depression			PMS		
Anxiety			Lower sex drive		
Panic attacks			Heavy periods		
Obsessive compulsive tendencies			Frequent periods		
Low self-esteem/confidence			Infrequent periods		
Low pain tolerance			Absence of period for more than 4 months		
Prone to addictions			Ovulation pain		
Psychosis			Lack of ovulation		
Frequent butterflies in stomach			Fluid retention		
Hyperactivity			Miscarriage		
ENDOCRINE			Infertility		
Gain weight easily			Pelvic cramps or "period pain"		
Find it hard to gain weight			Tender or painful breasts		
Lose weight easily			Painful intercourse		
Find it hard to lose weight			Menstrual blood clots larger than 10c piece		
Cold hands/feet			Hot flushes		
Warm/clammy hands/feet			Night sweats		
Highly affected if miss a meal			Vaginal dryness		
Excessive fatigue			Facial hair darkening or becoming coarser		
Decreased libido			Increased facial and/or arm hair growth		
Swelling/tightness in front of neck			Acne on face		
Frequently feeling cold			Acne on back		
Frequently feeling hot			Hair loss or thinning		
MEN ONLY			Take oral contraceptive pill		
Lower sex drive			Hormonal IUD		
Difficulty achieving/maintaining erection			Copper IUD		
Soft erection			Implanon		
Decreased ejaculate volume			Nuva Ring		
Increased abdominal fat			Hormone replacement therapy (HRT)		
Loss of muscle mass/strength			Excessive, smelly or coloured vaginal discharge		
Prostate enlargement			Thrush/candida		
Breast development				YES	NO
Hair loss			Are you pregnant?		
Significant testicular trauma			Are you trying to conceive?		
Infertility			Are you breastfeeding?		
Testicular pain					
Poor urine flow and/or dripping					
Painful ejaculation					
Loss/thinning of body and/or facial hair					
Thrush/candida					

Thank you for taking the time to complete this form. Please bring it with you to your appointment and/or email to hello@thesprout.com.au.
We look forward to working with you!

Ph: +61 424 955 265 **Email:** hello@thesprout.com.au **Web:** www.thesprout.com.au