New Patient Form

Date_________________

Mr/ Mrs/ Miss/ Other____________

First name_____________________Surname_________________________

Date of birth___________________Occupation_______________________

Address_______________________Postcode_________________________

Telephone_____________________Email____________________________

Referring Doctor (if applicable)_____________________________________

If you would like your Doctor to receive a report please provide name and address____

Private Health Fund____

Medicare details____

Food Allergies____

Medications/supplements____

Main reason for consult: (circle)

Weight Loss		Diabetes		Cholesterol		Blood Pressure

Irritable Bowel		Underweight		Other__________________________

How did you find out about *Paynt your life*? _________________________

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Privacy statement: All information shared within consults will be kept strictly confidential

Cancellation Policy: Please provide 24 hours' notice if you need to change your appointment, a $20 fine will be incurred if missed appointment is not notified

Patient signature__________________Date__________________________

Eat Well, Think Well, Live Well

Diet and Lifestyle

Meal Time	Solids	Liquids
Breakfast		
Mid-Morning		
Lunch		
Afternoon Tea		
Dinner		
Snacks/Desserts		

Hydration (circle) alcohol, fruit juice, soft drinks, energy drinks, coffee

Portions (circle) small moderate large

Appetite and cravings (circle): strong/poor, stable/varied

Skip meals?____

Eat out?____

Digestion: bloating/reflux/pains (circle) Does regularity fluctuate (loose/hard)?

____

Physical Exercise (type and frequency)____________________________

Energy levels (1-10)____stable or varied?__________________________

Stress Level (1-10) _____How do you find ways to relax/have time for self?

____

Sleep Quality/Time frame_____________________________________

Any recent changes?

____

____

Any current challenges?

____

____

What do you hope to gain from this consult?

____

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