PROACTIVE NUTRITION

HEALTH ASSESSMENT FORM

Surname:	**First Name:**
Street Address: **Suburb:** **State:**	**Postcode:**
Contact Phone:	**Email:**
Date of Birth:	**Occupation:**
Height:	**Current Weight:**
Emergency Contact:	**Emergency Phone:**
How did you hear about me?	
How many hours of exercise per week?	**0 1-2 2-3 3-4 4-5 5-6 7+**
If currently exercising please describe your training regime below:	
Day Time Activity Intensity Duration	
Are you currently training for an event? YES / NO **If yes please provide details eg event name, date, distance**	

HEALTH GOALS

What are your main health / fitness goals?.....

……..

……

……

What has stopped you achieving these goals in the past?.....

……

How motivated are you to working towards achieving your health goals?.....

……

PROACTIVE NUTRITION

HEALTH HISTORY

Do you suffer from any medical conditions?.....

……..

What if any major illnesses or hospitalisations have you had in the past?

.....

.....

.....

Are you currently seeing any other health care professionals?.....

……

Have you been treated by a Nutritionist or Dietician before? YES / NO

Any Known Allergies (please circle to indicate)

Dairy products	Tomatoes	Cigarette smoke
Soy products	Artificial flavours	Dust mites
Wheat	Alcohol	Grasses
Gluten	Metal jewellery	Pollens
Starch	Band Aids	Fur
Sugars	Cleaning products	Other.....

If female are you pregnant or are you currently trying to conceive? YES / NO

Do you smoke? YES / NO If yes how many per day? ……

Current medicines and / or supplements (include any vitamins or minerals)

Name of medicine / supplement include brand if known	Dosage per day	Since when?	Reason for taking

NUTRITIONAL STATUS

Are you happy with your current dietary habits? YES / NO

If No why?.....

Do you have any food allergies or food sensitivities? (please describe how your body reacts to these foods)……

……

……..

Do you have any special dietary requirements due to religion, beliefs or health conditions?.....

……

Please specify and list quantity if you have more than 2 units per day of the following, coffee, tea, soft drinks, energy drinks or alcohol……...

……

……

Are there any foods that you particularly crave?.....

……..

Are there any foods that aggravate you or are avoided?.....

……

Do you ever experience any of the following (please circle)

Bloating	Fatigue
Flatulence	Stress
Stomach Cramps or Heartburn	Anxiety / Depression
Diarrhoea	Sleep problems
Constipation	Nausea
Headaches / Migraines	Frequent colds / flu
Recurrent UTI's	Eczema or dry skin
Acne	Muscle Cramping / Twitching

Any other information regarding your health status?.....

……

PROACTIVE NUTRITION

Thinking of your cooking and eating habits please tick all that apply below:

- ☐ Often skip meals
- ☐ No time to cook / prepare healthy meals
- ☐ Enjoy cooking and trying new foods
- ☐ Tendency to stick to same foods / meals
- ☐ Tend to overeat or eat large portions
- ☐ Eat too fast or on the go
- ☐ Dislike cooking
- ☐ Often eat late at night or within 2 hours of bedtime

CONFIDENTIALITY & PRIVACY RIGHTS:

I hereby give consent to Proactive Nutrition (Jennifer Moulin) to provide Nutrition Consultations to myself. The consult will provide information and guidance about health factors within my control such as my diet, nutrition, lifestyle and supplements.

I understand that Jennifer Moulin is a Clinical Nutritionist, not a medical physician, and does not dispense medical advice, nor will she diagnose or treat any medical condition, but will provide nutritional support and education for an already diagnosed condition.

Medical records, health history and personal information I provide will be kept strictly confidential unless I consent to sharing medical information with other health professionals or if disclosure is required or sanctioned by law.

If you have any questions or concerns, please contact us for clarification.

PRINT NAME:_____

SIGNED: _____**DATE:** _____

HEALTH FUND REBATES

Jennifer Moulin is a member of the Australian Natural Therapies Association and registered with all applicable health funds. If you have private health insurance and are covered for Nutritionist consultations, rebates may apply. Please check with your health fund directly to confirm eligibility.

CANCELLATION POLICY

Clients may cancel or reschedule their consultations up to 24hrs prior. Less than 24hrs makes it difficult to re-allocate your booking time to other clients and therefore may attract a full consultation fee. Thank you for your understanding.

PAYMENTS ACCEPTED

Credit Card or Bank Transfer

PROACTIVE NUTRITION

Diet & Symptom Diary

****Please include all food and beverages consumed**

	BREAKFAST	LUNCH	DINNER	SNACKS	SYMPTOMS?	BOWEL MOVEMENTS
DAY 1	Time:	Time:	Time:	Time:	☐ Bloating ☐ Nausea ☐ Gas ☐ Cramping ☐ None	☐ Formed ☐ Loose ☐ Watery ☐ None
DAY 2	Time:	Time:	Time:	Time:	☐ Bloating ☐ Nausea ☐ Gas ☐ Cramping ☐ None	☐ Formed ☐ Loose ☐ Watery ☐ None
DAY 3	Time:	Time:	Time:	Time:	☐ Bloating ☐ Nausea ☐ Gas ☐ Cramping ☐ None	☐ Formed ☐ Loose ☐ Watery ☐ None
DAY 4	Time:	Time:	Time:	Time:	☐ Bloating ☐ Nausea ☐ Gas ☐ Cramping ☐ None	☐ Formed ☐ Loose ☐ Watery ☐ None
WEEKEND (SAT or SUN)	Time:	Time:	Time:	Time:	☐ Bloating ☐ Nausea ☐ Gas ☐ Cramping ☐ None	☐ Formed ☐ Loose ☐ Watery ☐ None