Wellness Rewired
Nutrition • Movement • Mindset • Sleep

Client Intake Form

Client's Detail

Name: Gender:

Address: Suburb:

Postcode: Phone: Mobile:

Email: Date of birth:

Ethnicity: Occupation:

What is the BEST way to communicate with you in between office visits?

☐ Home Phone ☐ Mobile ☐ Email Can a message be left (Yes /No): ☐

Emergency Contact Information

Name: Relationship: Mobile:

Health Care / Doctor Information

Name: Phone:

Clinic Address: Suburb:

Client's Consent

☐ Services and Disclosure: I acknowledge that I have been informed about and consent to clinical nutrition consultations and services from Wellness Rewired Pty Ltd personnel (the "Practitioner"). I have disclosed all relevant medical conditions, allergies, dietary restrictions, and medications, and will promptly inform the Practitioner of any changes.

☐ Medical Oversight: I agree to consult with and obtain clearance from qualified medical professionals before implementing any changes to prescribed treatments or medications, and will not disregard or delay seeking professional medical advice based on information received from the Practitioner.

☐ Limitations and Risks: I acknowledge that results and success may vary between individuals based on adherence to recommendations and other factors. While improved wellness practices may be beneficial, they do not guarantee protection from illness, and the information provided may differ from traditional therapeutic approaches.

☐ Privacy and Documentation: I consent to the documentation and secure storage of my progress, measurements, and assessments for record-keeping purposes, understanding that my privacy will be protected in accordance with applicable laws.

☐ Liability Waiver: I expressly and irrevocably accept sole responsibility for my decision to use the Practitioner's services, acknowledge all associated risks, and waive any right to claims or liability against the Practitioner regarding the provided information and services.

☐ Third-Party Information: I understand that any third-party information or recommendations provided by the Practitioner may not reflect their views, should be independently verified, and does not imply their endorsement or liability.

☐ Intellectual Property: I agree not to circumvent this agreement or use any provided information for financial benefit without the Practitioner's involvement.

☐ Emergency Contact: I have provided accurate emergency contact information and understand it may be used if necessary during consultations.

Signature

By signing below, I confirm that I have read, understood, and agree to all terms and conditions outlined in this document. I acknowledge that this is a legally binding agreement between myself and the Practitioner.

Client's Signature:

Date:

Practitioner's Signature:

Date:

Preassessment Questionnaire

What is your main presenting condition/concern today? (please list 1-2 items maximum)

Do you have any children? If so, please list their ages:

Are you trying to conceive? ☐ Yes ☐ No Have you sought reproductive assistance? ☐ Yes ☐ No

If yes, for how long have you been actively trying?

Do you have any known allergies? If so, please list them.

If you do have allergies, please explain what happens upon contact/ingestion:

Are you a smoker? ☐ Yes ☐ No If yes, quantity per day: Are you looking to stop? ☐ Yes ☐ No

Have you experienced any fractures or had any surgeries? If yes, please list details of the injury and when, along with any past surgical procedures:

Weight History

Would you like to be weight today? Yes No

Height: Weight: Desired Body Weight:

Highest adult weight: When? Weight 1 year ago:

Have you had any recent changes in your weight that concern you? Yes No

If yes, please explain:

Usual Food Intake

Compared to your normal food intake, has your current food intake changed during the past month?

Unchanged More than usual Less than usual

Have you made any major dietary changes recently? (If yes please explain)

Please check any of the following problems which have kept you from eating adequately over the past 2 weeks

- Poor appetite
- Food tastes different
- Dry mouth
- Mouth sores
- Nausea
- Smells bother me
- Difficulty swallowing
- Diarrhoea
- Feel full quickly
- Pain on swallowing
- Fatigue
- Pain in general: where

In your opinion, what do you think are the three least healthy foods you eat each week and why?

In your opinion, what do you think are the three most healthy foods you eat each week and why?

Digestive History

Do you associate any digestive symptoms with eating certain foods? Yes No

If yes, please explain:

How often do you have a bowel movement?

Do you need to take laxatives? Yes No If so, what type/brand and how often?

Meal Preparation

What % of your food is home cooked? % How many days / week do you typically eat out?

3 Day Food Diary

Please keep a food diary for 3 days - preferably 2 weekdays and 1 weekend day. Write down all the foods and drinks consumed. Please include how much (the amount you ate or serving size) and any information about how it was prepared (i.e. baked, grilled, sautéed).

Breakfast	Breakfast	Breakfast
Lunch	Lunch	Lunch
Dinner	Dinner	Dinner
Snacks	Snacks	Snacks

Exercise & Other Lifestyle Habits

What type of exercise do you enjoy? (eg walking, running, swimming)

How often do you exercise?

- ☐ 1 - 2 days / week
- ☐ 3 - 4 days / week
- ☐ 5 - 7 days / week
- ☐ I don't exercise very often because I don't really enjoy it
- ☐ I enjoy exercising but I'm short on time

How long do you exercise when you can?

- ☐ Less than 30 minutes / workout
- ☐ 30 - 45 minutes / workout
- ☐ >45 minutes / workout

What are your leisure activities or hobbies?

Do you drink alcohol? ☐ Yes ☐ No If so, how many and how often? ☐ drinks/day ☐ drinks/week

Do you use recreational drugs? ☐ Yes ☐ No

Other information you would like to share:

Health History

Symptoms	C	P
Pain & Stiffness		
At night		
Back		
In morning		
Legs		
Neck / Jaw		
Shoulder/Arm/Hand		
Pins & Needles / Tingling		
Arms/hands/fingers		
Legs / feet / toes		
Other		
Numbness		
Arms/hands/fingers		
Legs / feet / toes		
Other		
Cold Extremeties		
Hands		
Legs / feet		
Swelling		
Arms / hands		
Legs / feet		
Balance Concerns		
Loss of balance		
Vertigo		
Weakness/clumsiness		
Respiratory Issues		
Asthma		
Chronic bronchitis		
Chronic cough		
Cough		
Difficulty breathing		
Hay fever		
Sinus problems		

Symptoms	C	P
Digestive Symptoms		
Abdominal Discomfort		
Constipation		
Diarrhoea		
Gastric ulcers		
Indigestion		
Nausea / Appetite		
Reflux		
Renal System		
Sense of incomplete emptying		
Frequent urination		
Incontinence		
Interstitial cystitis		
Poor urine stream		
Urinary tract pain		
Immune System		
Allergies		
Chronic fatigue		
Fibromyalgia		
Frequent colds / flu		
Frequent UTIs		
Glandular fever		
IBD - Crohn's or UC		
Multiple sclerosis		
Heart & Circulatory		
Blood clots / DVT		
Chest pain		
Heart problems/Angina		
High blood pressure		
Low blood pressure		
Pacemaker		
Stroke (CVA)		
Varicose veins		

Symptoms	C	P
Skin		
Bruise easily		
Dermatitis		
Eczema		
Itching		
Psoriasis		
Rashes		
Urticaria / Hives		
Wounds slow to heal		
Neurological System		
Altered alertness		
Body fatigue		
Changes in vision		
Confusion		
Depression / Anxiety		
General muscle weakness		
Memory Loss		
Muscle cramps		
Mental health (other)		
Seizures		
Senses		
Blurred vision		
Dizziness/Lightheaded		
Fainting		
Headache		
Heavy headed		
Loss of hearing		
Loss of smell		
Loss of taste		
Speech impairment		
Tinnitus		
Visual impairment		
Visual light sensitivity		

Symptoms	C	P
General Wellbeing		
Fatigue		
Fevers		
Fog		
Irritability		
Nervousness		
Sleep problems		
Stress		
Tension		
Other		
ADHD / Autism / Asperger's		
Breastfeeding		
Cancer		
Diabetes Mellitus		
Difficult menstruation		
Erectile dysfunction		
Fertility problems		
Hepatitis B / C		
HIV / AIDS		
Low / Loss of libido		
Menopause		
Painful intercourse		
Pregnancy		
Premenstrual syndrome		
Prostate problems		
Testicular pain		
Sweats		
Other (add if not listed)		