Welcome to

Institute of Sports and Spines

Nutrition New Patient Information Form

Title:_____ Name:_____ Middle Initial/s:____ Surname:_____

Home Address: _____ Suburb: _____ Postcode: _____

D.O.B._____ Phone**:** Home: _____ Work: _____ Mob: _____

*If you are a **current patient** of Institute of Sports and Spines, please skip to **'Reason for Visit' section below.***

E-mail address: _____

Private Health Fund: _____ Memb. No. _____ No. on Card ___

Medical Practitioner's (GP) Name: _____ Phone: _____

Next of Kin/Emergency Contact:_____ Relationship: _____ Ph: _____

Name of person who referred you to us or how did you hear about us? _____

What is your occupation or major daily activity? _____

Hobbies / Sports / Specific Health interests: _____

Do you exercise regularly? If so please give details: _____

I would like to receive marketing emails from Institute of Sports and Spines ☐ Yes ☐ No

REASON FOR VISIT: _____

What are your specific goals/aspirations? I.e. weight gain, weight loss, body composition, mood/self-esteem, etc.

_____

When do you want to achieve this by (i.e. a date)?

_____

Please describe how many times/day you eat & and at what times (I.e. Breakfast 5:00am, Morning Tea 8:00am, Lunch 12:00pm, Afternoon Tea 3:00pm, Dinner 7:00pm, Supper 9:00pm).

_____

_____

Do you have any performance goals? If yes, please elaborate.

_____

Do you have any dietary preferences (i.e. carnivore, vegetarian, vegan, flexitarian, etc.)?

_____

Do you have any dietary **allergies** or **intolerances** (i.e. Coeliac Disease, lactose intolerant, gluten, peanuts, tree nuts, fish, salicylates, etc.)?

_____

How many cigarettes per day do you smoke? _____ How many previously and when did you quit? _____

How many days per week do you drink? _____

On these days, how many standard drinks do you consume? (eg: 375mL 3.5% Mid-strength can/stubbie; 100mL 13% Wine; 1 nip (30mL) 40% Spirits, **all = 1 standard drink**). _____

Headaches: ☐ Yes ☐ No Dizziness: ☐ Yes ☐ No

Have you had a recent change in? ☐ Weight ☐ Taste ☐ Smell

Please list and elaborate: _____

Have you had or do you have existing ailments (If so please give details):

☐ Major Accident's _____

☐ Medical Tests / Blood tests _____

☐ Surgery _____

☐ Medication _____

☐ Illness _____

☐ Infection / fever _____

☐ Recent GP visit _____

☐ Other _____

Have you previously, or do you currently experience any of the following conditions?

Are you pregnant	☐	Stroke/DVT	☐	Cancer	☐	Thyroid Disorders	☐
Epilepsy	☐	Anxiety	☐	Digestive	☐	Emotional Disorders	☐
Bowel/Bladder	☐	Insomnia	☐	Stress	☐	Sexual Dysfunction	☐
Migraines	☐	Auto-Immune Disorder	☐	Blood/Heart Disorders	☐		

Please give details: _____

_____

Do you have a family history of: ☐ Stroke ☐ Heart/Blood Disorders ☐ Cancer/Malignancy ☐ Diabetes ☐

Other ☐ Please List: _____

The below table provides our Practitioners with an accurate depiction of your energy output for the week. This information can be used for general health & fitness goals or Body Composition Analysis. Your total for all activities must equal 168 hours (hrs/week). ***Please be as honest and accurate as possible when logging your hours.***

Activity	Activity description	How many hours/week?
Sleeping	Sleeping (The average person sleeps between 7-9 hours per night)	
No activity	Lying down, relaxed but not sleeping (maybe reading in bed)	
Very light	This includes sitting, studying, talking, little walking	
Light	Typing, shop work, etc. Typically office work, sitting at the desk.	
Moderate:	Walking, jogging, gardening. This is light manual labour.	
Heavy:	Heavy manual labour, such as digging, tree felling, climbing (typically sweating activity)	
Exceptionally heavy:	Fitness oriented cycling, vigorous activity, weight training, aerobic dance	
Sports:	Vigorous sports, competition such as football, tennis or other extended-play sports	
All out training:	**Extremely high intensity** training with little rest in between sets or exercises.	
Extended Maximum Effort	**Maximum performance/Extreme high intensity** and high duration sports competition such as **triathlon, cross country, skiing or marathon**	
		ABOVE COLUMN MUST = 168 HOURS

Consent

If you have any questions related to the advice you are about to receive, please speak with the Practitioner.

I have discussed the above information with the Practitioner and understand any risks which may result from the advice provided by the Practitioner. I give my consent to any nutritional advice which has been provided to me. In signing this document, I agree to indemnify the Provider of this service and its employees, agents and representatives from claims made against them in the event that I experience a reaction to the nutritional advice provided.

We value your time and appreciate helping you with your health care needs. Your appointment is important to us. As missed appointments may inconvenience other patients, our clinic has adopted a policy of charging a normal consultation fee for missed appointments and appointments cancelled without 4 hours' notice. We hope that this does not inconvenience anyone too much and should ensure in future that you have the best opportunity of having your needs met in an appropriate time frame.

COVID-19

Due to the current global pandemic I understand the risks that are associated with face to face appointments.

I understand that I am opting to receive advice that is not urgent or medically necessary and have the ability to defer my session to a later date. Whilst I understand the risks associated, I agree to proceed with the current appointment time.

I confirm that I have not been in contact with someone confirmed, or suspected of COVID-19.

I confirm that I am not experiencing any of the following symptoms of COVID-19 below.

☐ Fever	☐ Dry Cough	☐ Sore Throat
☐ Running Nose	☐ Shortness of Breath	☐ Loss of Taste/Smell

Print Full Name: _____

Patient's Signature (or Legal Guardian): _____

Date: / /