



Dear new client

Thank you for making an appointment to see me regarding your health & wellbeing and congratulations in taking the first step towards achieving your desired health goals.

Before you complete the following medical case history form, I would like to explain a little about my background, philosophy and approach to your care, so that when you come to see me for the first time, you can be familiar with the direction we will be taking in relation to your treatment.

I first became interested in nutritional medicine after suffering from Chronic Fatigue Syndrome and Lupus in my early 20's. During that time, I saw many medical practitioners & specialists, before reaching the conclusion that orthodox medicine alone could not completely heal my condition or enable my body to return to a level of optimal health, experienced previously as an elite runner. I was subsequently left with no definitive answers to my health problems, other than medications to relieve symptoms only and in many cases, induce additional undesirable side effects.

Eventually it dawned on me that if I had previously experienced great health, then my body must be capable of finding its way back there again, all I had to do was find a way to create the ideal environment for it to be healthy once more.

I was fortuitous enough to stumble across the concept of healing the body with whole foods and nutritional medicine. After healing my body through this modality and adopting a mind / body approach to my health, compared to merely observing and treating symptoms, I enrolled in a Bachelor of Human Health Science and an Advanced Diploma in Clinical Nutrition to formalize what I had learnt through my own experiences. I continue to expand on my knowledge through attending innumerable national & international seminars and conferences, to ensure I continually stay abreast of the most up-to-date scientific information & offer my patients the most thorough and comprehensive nutritional medicine treatment options available.

Today, I work as a Clinical Nutritionist in my own practice, where I implement Functional & Nutritional Medicine treatment programs, in dealing with a vast range of health conditions, ranging from digestive disorders, fatigue / adrenal exhaustion, women's health - including hormonal imbalances relating to PMT , depression anxiety, menopause & thyroid conditions, natural fertility management, headaches/migraines, natural solutions for high blood pressure & cholesterol, weight loss/ gain, detoxification & anti ageing programs, allergies, asthma, chronic fatigue syndrome, Lupus, Type I and II diabetes, skin disorders including acne & eczema, ADHD & Autism and many more.

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Adopting a holistic and preventative approach to your health is key in the treatment & prevention of many health disorders & disease, particularly when the patient has not responded effectively to orthodox medical treatment alone.

As a Clinical Nutritionist, my philosophy to your treatment, is to act as a facilitator by guiding you in making the best dietary & lifestyle choices and modifications, and where necessary, prescribe the appropriate nutritional & herbal supplements to assist in correcting any underlying nutrient deficiencies and biochemical / metabolic imbalances. To ensure that the results are enduring, I place a heavy emphasis on educating you as to how to maintain your improved state of health so that you are in control of your body and ultimate health.

Important Please Read

Before your first consultation

- After downloading this form from my website you will need to save it to your computer, complete it and then email it back to me as attachment to sally@sallyjoseph.com.au. If this is not possible then please bring the completed copy to your consultation, or fax it to me on **07) 38461268**, as it is more efficient if I can review this form prior to our consultation. Any questions you cannot answer we can decipher during your consultation. **NB – please be aware that if you do not save this document to your computer before typing on it, any additions you make will not be saved when you email it back to me)**
- Very important – before your initial consultation please go to my website www.sallyjoseph.com.au and ‘create a profile’ or register – this function is located on the home page, along the top menu bar. This will then allow me to load all relevant information relating to your case, treatment program and consultation notes under a password protected file that you can then access 24 hrs 7 days per week.
- If you are located in Sydney, I recommend you attend the pathology lab **Australian Biologics** for a Live Blood Cell and Clot Retraction test. These tests provide a comprehensive assessment of your overall digestive function, immune status, adrenal activity & specific nutrient levels. These tests are vital in assisting me to make a comprehensive and effective assessment of your health & implement the most effective treatment program for your condition. If you do not live in

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Sydney, arrangements will be made at the time of your initial consultation for alternative pathology tests.

- **Australian Biologics testing laboratory can be contacted on 02 9283 0772. Please request a CRT 'collect' and an LBA and state that I have referred you** - to ensure I receive a copy of your results. Allow up to 45 mins for the assessment.
These tests are not covered by Medicare but please ask the receptionist if your private health insurer provide rebates for this lab. The total cost for the pathology tests is \$140.

Australian Biologics are located at Fayworth House, L6, 383 Pitt St Sydney. (Cnr of Liverpool St). They are open Mon to Fri between 8am and 5pm and the first Saturday of each month between 9am & 12pm.

Please avoid mobile phone use 2 hrs prior as they can create a false positive in certain areas of the assessment.
(using your phone for text or brief calls on loud speaker - held away from your body, if necessary is ok.)

- Phone consultations – If you are unable to attend a consultation in Sydney, you can schedule a time for a consultation via phone or skype. Please arrange a suitable consultation time via email - eileen@sallyjoseph.com.au or by calling 1300 DETOXNOW. - 1300 338 669 669

What to expect in your first consultation

- The first consultation is designed to provide each patient with a thorough, individual and holistic assessment, based on your pathology results from Australian Biologics, your medical case history, diet, lifestyle & symptomatology.
- The initial face to face consultation will also include a Cellular Age Test. This quick, non invasive test provides the most accurate measure of your body fat : muscle ratio, toxicity levels, biological age – based on fat mass and cellular health, recommended calorie intake to obtain your optimal weight, fluid /electrolyte balance & hydration levels.

What will it cost me?

The initial clinic consultation last approximately 2 - 2.5hrs & is charged at \$300. This includes a written assessment of your Australian Biologics pathology results, Cellular Age Test, a 60 page comprehensive recommended eating program, and a written treatment program. Please note any nutritional



supplements prescribed to aid in restoring your health, are charged in addition to the consultation fee. Home visits are charged at an extra \$25 per person

NB - If you are having a phone consultation, this will be charged according to the duration. Consultations are charged at \$125 p hr. Please note the Bio Impedance test cannot be performed for a phone consultation, hence the cost is not included in this rate.

Please note email and phone consultations will only commence once a valid credit card has been provided and verified. Visa & MasterCard are accepted.

Follow up Consultations

- It is recommended that you attend a follow up consultation no more than 4 - 6 wks from your initial consultation. This period allows for enough change to occur in your health so that we can then reassess your case and ongoing treatment program if any, beyond this point.
- Please be aware that it is important to schedule this well in advance due to the fortnightly clinic schedule. If you are unable to attend a consultation, you may request a phone or email consultation.
- Follow up consultations usually average 1 hr max and are charged at \$125 per hour. Please note additional Cellular Age tests are charged at \$35
- Please note, all advice provided by myself, concerning your case & treatment program – excluding menial matters relating to instructions for the treatment program, are deemed to be a consultation, whether they are sent via email or handled over the phone and are charged at \$35 p/15 min increments
- The success of achieving your health goals, will ultimately be determined by your adherence and dedication in applying the advice I recommend and the treatment program prescribed for you.



Please note all information provided within this document is strictly confidential and will not be divulged to any other party without your prior consent

Surname First name

Address Post code

Contact numbers h) w) mob)

email

DOB / / Occupation

DR- GP Ph

Referred by

Height cm

Weight (if known) kg

Blood type (if known) - A/B/AB/O

Please list all medication (both prescription & non prescription, for past 6 months and any vitamin supplements you are currently taking and doses/ number of tablets p/d for each.

How do you rate your present level of health?
Rate 1-10 being excellent ()



When was the last time you felt really healthy & well with lots of energy?

What health goals would you like to achieve?

How committed are you to improving your health status?

Rate 1-10. 10 being highly committed ()

Are you willing to change your lifestyle habits? Yes () No

What do you feel has contributed most to your current health situation, if known? (eg: stress, poor diet, lack of sleep, excessive bad lifestyle habits, genetics)

Why Have you come for treatment? If the reasons are multiple, state the 3 most important ones

How long do you feel it will take to achieve your desired health & lifestyle goals

Days () Weeks () Months () Years () ongoing ()

List your current symptoms & how long you have suffered from these.

What kind of treatment have you had for the above conditions?

Have you ever used antibiotics? If so what for, for how long & approximately how many times and please state the last time you took them .

Yes/ No



Have you ever taken steroid drugs such as cortisone? If so what for and approx. how many times.
Yes / No

What vaccinations have you had and the age of first one if known? Eg: childhood/travel overseas/flu

Did you experience any adverse reactions to them? Yes/No

Have you ever experienced adverse reactions to treatment or medication, including general anesthetics? If so when, provide details on effects

Did you have any recurrent childhood illnesses & treatment? EG: Asthma, bronchitis, tonsillitis, urinary tract infections, middle ear infections, eczema, etc

Were you breast fed as a baby? If so for how long Yes/No

Please list any major operations / surgery and when they occurred.

Please list any major adult illnesses and when they occurred.



Are you aware of any known allergies or possible allergy symptoms including sinus congestion, hay fever, excess mucous production, skin rashes, head aches, bowel disturbances, abdominal bloating fatigue after eating ? **If so please list**

Have your symptoms been affected by different locations? Eg: different house, country, areas that you have lived or worked?

Do you come into contact with any chemicals at home or at work? If so what type

Are you aware of any mould or mustiness in your home or work environment? Yes/No

Do you have any food cravings or aversions? If so what for and are they worse at any time of the day or night/month

Do you have any particular eating pattern? Eg: vegetarian, macrobiotic, low fat, diabetic etc Yes/No

How long have you followed this diet?

List all the foods and drinks you consumed in the past three days?

Day one

Breakfast

Lunch



Dinner
Snacks
Cups of coffee Cups of tea Alcoholic beverages – (units 1 standard beer or wine = 1 unit)

Day two

Breakfast
Lunch
Dinner
Snacks
Cups of coffee Cups of tea Alcoholic beverages – (units 1 standard beer or wine = 1 unit)

Day Three

Breakfast
Lunch
Dinner
Snacks
Cups of coffee Cups of tea Alcoholic beverages – (units 1 standard beer or wine = 1 unit)

Is this a typical eating pattern Yes/No

How many glasses of water do you drink each day? _____
Is it filtered, bottled or tap _____

How often do you have a bowel motion? _____

Please indicate which of the following is most typical for you

- a) Stools are usually easy to pass and well formed
- b) Stools are usually difficult to pass and dry
- c) Stools are often loose
- d) Stools are commonly a mix between a) b) c)?

Are your stools ever pale in colour or very dark on a regular basis? Yes/No



Do you smoke? If yes, how many p/d _____ Yes/No

Do you drink alcohol? If yes, please indicate how many standard drinks you would have in a week and what you drink _____ Yes/No

Do you take or have you ever taken recreational drugs? If yes please detail which drugs you have taken and the amounts and frequency. (It is important to provide this information accurately as it will provide information relating to your nervous system function and endocrine (hormone balance)

Do you take part in regular physical activity? If yes what and how often _____ Yes/No

What is your best & worst time of day? Eg- Feel good /bad on waking, tired after lunch/early evening etc _____

What time do you go to bed at night? _____

How long does it take you to get to sleep? _____

What time do you wake _____

Is your sleep restful or is it broken? please describe sleeping pattern _____

Do you sleep on an electric blanket or water bed? _____ Yes/No



This page is to be completed by ladies only

Ladies, do you have or have you had pregnancies / terminations Yes/No

Do you take or have you ever taken the contraceptive pill – if yes please detail for how long and when the last time was if not currently Yes/No

If you are on the contraceptive pill are your reasons for taking it related to contraception only or to control symptoms associated with your periods? Please provide details _____

How old were you when you first got your period _____

How many days is your typical menstrual cycle? (note the first day of your cycle is day 1 of bleeding through to the last day before your next period) _____

How many days you typically bleed? _____

How heavy is the flow and on what days it is heaviest? _____

Are your periods ever irregular periods? Yes/No

Do you suffer any of the following symptoms leading up to or during your period? please indicate – depression, anxiety, aggression, mood swings, lower abdominal cramping, clotting, headaches, fatigue, sugar / carbohydrate cravings



Do you have any silver fillings? (Amalgams), If so how many	Yes/No
Do you grind your teeth or have a bite problem?	Yes/No
Do you have any root canals? (dead tooth with a post)	Yes/No
Do your gums bleed when you brush your teeth if yes, occasionally or frequently	Yes/No
Are you aware of any muscular or structural problems?	Yes/No
Do you have or have you ever had whip lash	Yes/No
Have you ever had any fractures?	Yes/No

Is there any other information that may be helpful or relevant?



Family History

Please list any health problems, diseases etc suffered within your family.
EG – Cancers, diabetes, heart disease, liver disease, high cholesterol, high/low blood pressure, depression, anxiety, alcoholism, obesity, etc.

Mother
Father
Siblings

Maternal Grandmother
Maternal Grandfather

Paternal Mother

Paternal Father