Jacinta Callaghan

Nutritional Doctor

B.HSc.(Nutritional Medicine)

Nutritional Medicine - the natural path to optimum health.

Thank you for choosing me to support you on your pathway to better health and wellbeing. I look forward to supporting your choice to restore what nature intended for you!

Please fill out the information below as best you can before your appointment. This will allow me to spend more time on you and your health during your first visit.

All information contained on this form and during your consultation will be treated with the utmost confidentiality and no information will be given to any persons without your direct consent.

I look forward to seeing you soon.

Jacinta Callaghan

Appointment Date: …. / …. / …… Time: …………………

What to bring:

Any previous medical test results

Any letters or paperwork that may have been provided by your GP or other medical professional

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PERSONAL DETAILS:

NAME	
PREFERRED NAME	
ADDRESS	
EMAIL	
NEWSLETTER Would you like to receive our regular newsletter Yes ( ) No ( )	
TELEPHONE (BH)	MOBILE
DATE OF BIRTH	
EMERGENCY CONTACT NAME:	
PHONE:	RELATIONSHIP TO YOU:
FAMILY DOCTOR'S NAME DOCTOR'S ADDRESS	
WHO REFERRED YOU? FACEBOOK ( ) FRIEND ( ) DOCTOR ( ) OTHER ( ) IF OTHER, PLEASE PROVIDE DETAILS: CONCESSIONS HEALTH CARE YES ( ) NO ( ) PENSIONER YES ( ) NO ( ) STUDENT YES ( ) NO ( )	

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PRIVATE HEALTH FUND YES ( ) NO ( ) IF YES, NAME: **What is/are the main health concerns that you have come to see me today?**
Have your received prior treatment for this/these conditions? If yes, please details below:
Have you had any major health issues in the past ? If yes please detail below:

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Do you have any of the following allergies or intolerances? Please tick for those with yes:

Dairy		Tomatoes		Cigarettes (smoke)	
Soy Products		Artificial flavours		Dust mites	
Yeast		Artificial Colours		Wheat	
Alcohol		Grasses and Pollens		Gluten	
Jewellery		Bandaids		Sugar	
Cleaning Products		Fur		Starch	

Medicines: Yes ( ) No ( )
Please detail

Other:
Please detail

Occupation/Type of work or daily routine: What type of activity does your day mostly consist of… eg desk/computer/driving

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Please name any current medicines and /or supplements that you are taking:

NAME	DAILY DOSE	REASON FOR TAKING	DURATION OF USE

OTHER INFORMATION YOU WOULD LIKE TO PROVIDE:

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What type of food do you normally eat? Please note down the foods and beverages that you have consumed in the last 24 hours and observed adverse effects if any.

TIME	**CONSUMED**	**ADVERSE EFFECTS**
BREAKFAST		
MORNING TEA		
LUNCH		
AFTERNOON TEA		
DINNER		
SUPPER		
SNACKS OR BEVERAGES		

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