Dr Kristian Ronacher

"The Good Food Doctor" - *Let food be your medicine*

Optimal health is a feeling and embodiment of vitality, clarity, wellness and balance.

By learning more about your current state of health, your lifestyle and habits, along with your medical and family history, I can be of better assistance to you and make sure that the health and nutrition coaching, advice and support provided is a good fit for your goals and individual needs. My intention is to bring your physical, mental, emotional and energetic aspects back into balance; in order for you to live an empowered and inspired life.

Enjoy and embrace your journey!

DR KRISTIAN RONACHER: CLIENT ASSESSMENT FORM DATE: / /

Name: Age: DOB: / /

Address: Postcode:

Phone: H: M: W:

Email:

Emergency Contact: Phone:

Relationship status: ☐ Single ☐ Engaged ☐ Separated ☐ Defacto ☐ Partner ☐ Married ☐ Divorced ☐ Widow/er

Family composition: ☐ Mother ☐ Brother/s ☐ Sons/Daughters ☐ Step Mother/Father ☐ Father ☐ Sister/s ☐ Step Sons/Daughters ☐ Step Brother/Sisters

Occupation: Previous:

Current non-work related interests / hobbies / activities / sports:

How did you hear about Dr Kristian Ronacher? ☐ Word of mouth ☐ Internet / Website ☐ Facebook ☐ Practitioner Referral (e.g. Massage, Chinese Medicine Doctor, Physio, Chiro, etc.) ☐ Advertisement ☐ Other

Name of Referrer (if known):

How do you prefer me to contact you? ☐ Email ☐ Phone ☐ Text ☐ Skype or other video chat ☐ Other (please specify):

Top 5 reason for consultation/program (or goals):

1.
2.
3.
4.
5.

Have you seen or are you seeing another practitioner for this health goal or medical condition? ☐ Yes ☐ No

Please list other therapies and therapists used:

☐ I give permission for Dr Kristian Ronacher to contact other practitioners to help achieve my health goals.

Signed: Dated: / /

MEDICAL HISTORY

In order for you to gain the most benefit from this program, we encourage you to answer all of the following questions. If you are uncomfortable with answering a particular question, feel free to leave it blank. Please expand all YES answers in the 'notes' spaces provided (if required).

PERSONAL MEDICAL HISTORY

Have you ever had any of the following conditions?

YES	NO		YES	NO		YES	NO	
☐	☐	Allergies	☐	☐	Dermatitis	☐	☐	Liver disease / problems
☐	☐	Anaphylaxis	☐	☐	Embolism(s)	☐	☐	Lupus
☐	☐	Anaemia	☐	☐	Eczema	☐	☐	Mental Illness
☐	☐	Angina	☐	☐	Glandular Fever	☐	☐	Pancreatitis
☐	☐	Anxiety	☐	☐	Growths	☐	☐	Psoriasis
☐	☐	Aneurysm(s)	☐	☐	Heart attack	☐	☐	Rosacea
☐	☐	Asthma	☐	☐	Heart failure	☐	☐	Skin condition, other: _____
☐	☐	Autoimmune disease	☐	☐	Heart murmur	☐	☐	Skin lesion / rash
☐	☐	Blood clot(s)	☐	☐	Heart valve abnormality	☐	☐	Stroke
☐	☐	Cancer (including skin cancer)	☐	☐	Hemochromatosis	☐	☐	Thrombosis (incl. DVT)
☐	☐	Cyst(s)	☐	☐	Hepatitis	☐	☐	Thyroid trouble
☐	☐	Depression	☐	☐	Herpes (Type 1 or 2)	☐	☐	Tumour(s)
☐	☐	Diabetes / Insulin resistance	☐	☐	Kidney disease / problems	☐	☐	Ulcer

Notes:

REVIEW OF CONDITIONS

Do you currently have or have you recently had any of the following?

CENTRAL NERVOUS SYSTEM

YES	NO	
☐	☐	Autisum / Aspergers / ADHD / ADD
☐	☐	Bi-polar
☐	☐	Convulsions/seizures
☐	☐	Difficulty concentrating
☐	☐	Epilepsy (type, frequency)
☐	☐	Fainting spells
☐	☐	Frequent headaches
☐	☐	Irritability
☐	☐	Loss of consciousness
☐	☐	Loss of coordination
☐	☐	Mania
☐	☐	Memory loss
☐	☐	Mental fatigue
☐	☐	Migraines
☐	☐	Nervousness
☐	☐	Numbness/Tingling in body
☐	☐	Numbness/Tingling in extremities
☐	☐	Numbness/Tingling in face/head
☐	☐	Panic attacks
☐	☐	Paranoia
☐	☐	Recurrent dizziness
☐	☐	Trembling or Tics
☐	☐	Tremors
☐	☐	Other: _____

PULMONARY / RESPIRAORY

YES	NO	
☐	☐	Breathing, noisy rattling sounds
☐	☐	Bronchitis
☐	☐	Brown/blood-tinged sputum
☐	☐	Bluish nails or lips
☐	☐	Chest tightness
☐	☐	Chronic or Frequent cough
☐	☐	Colds always "go to chest"
☐	☐	Cough, dry or moist
☐	☐	Difficulty breathing
☐	☐	Excessive mucus production
☐	☐	Mucus & Congestion
☐	☐	Pain in chest
☐	☐	Pleurisy / Pleuritis
☐	☐	Pneumonia
☐	☐	Pulmonary oedema
☐	☐	Shallow breathing
☐	☐	Shortness of breath
☐	☐	Wheezing
☐	☐	Other: _____

GASTROINTESTINAL

YES	NO	
☐	☐	Belching / Burping
☐	☐	Black/bloody bowel movement
☐	☐	Bloating / Sense of fullness
☐	☐	Bowel issues
☐	☐	Colitis / Crohn's Disease
☐	☐	Digestive problems
☐	☐	Diverticulitis
☐	☐	Flatulence / Excessive gas
☐	☐	Frequent abdominal cramping
☐	☐	Frequent abdominal pain
☐	☐	Frequent indigestion / Heartburn
☐	☐	Frequent nausea
☐	☐	Gastric (acid) reflux
☐	☐	Hemorrhoids
☐	☐	Hernia
☐	☐	Irritable Bowl Syndrome (IBS)
☐	☐	Leaky gut syndrome
☐	☐	Loss of appetite, or nausea
☐	☐	Persistent constipation
☐	☐	Persistent diarrhea
☐	☐	Trouble swallowing
☐	☐	Undigested food in stools
☐	☐	Vomiting blood / bile
☐	☐	Other: _____

REVIEW OF CONDITIONS (CONTINUED)

Do you currently have or have you recently had any of the following?

EYES, EARS, NOSE, THROAT

YES	NO	
☐	☐	Adenoids
☐	☐	Bad breath
☐	☐	Bleeding gums
☐	☐	Blurred or double vision
☐	☐	Braces (have had or currently have)
☐	☐	Change(s) in vision
☐	☐	Dental / Orthodontic problems
☐	☐	Dental decay / erosion
☐	☐	Dental / Jaw deformities or reconstruction, etc.
☐	☐	Deterioration of vision
☐	☐	Difficulty with night vision
☐	☐	Dry mouth
☐	☐	Earaches
☐	☐	Ear infections / issues
☐	☐	Far sighted
☐	☐	Frequent nosebleeds
☐	☐	Frequent sinus trouble
☐	☐	Grommets
☐	☐	Hay fever or Rhinitis
☐	☐	Loss of hearing
☐	☐	Loss of smell
☐	☐	Menieres disease (excess of fluid in the inner ear)
☐	☐	Near sighted
☐	☐	Recent hoarseness
☐	☐	Ringing / Buzzing ears
☐	☐	Speech impediment / Lisp
☐	☐	Stuttering
☐	☐	Tongue cracking / Sores
☐	☐	Other: _____

MUSCULOSKELETAL

YES	NO	
☐	☐	Arthritis or Rheumatism
☐	☐	Back trouble / pain
☐	☐	Bone aches / pains
☐	☐	Carpal tunnel syndrome
☐	☐	Joint injury / pain / swelling
☐	☐	Muscle cramps
☐	☐	Muscle pains
☐	☐	Neck trouble / pain
☐	☐	Other: _____

GENITO-URINARY

YES	NO	
☐	☐	Bed wetting
☐	☐	Bladder trouble / Incontinence
☐	☐	Blood in urine
☐	☐	Candida / Thrush
☐	☐	Currently pregnant
☐	☐	Cystitis (recurring)
☐	☐	Cysts (Ovarian / Testicular)
☐	☐	Difficulty starting urination
☐	☐	Difficulty stopping urination
☐	☐	Ectopic pregnancy
☐	☐	Endometriosis
☐	☐	Fertility issues (Infertility)
☐	☐	Fibroids
☐	☐	Frequent or painful urination
☐	☐	Irregular periods
☐	☐	Loss of libido
☐	☐	Painful periods (cramping)
☐	☐	Problems with sexual function
☐	☐	Prostate infection / Prostatitis
☐	☐	Vaginosis
☐	☐	Urinating 1 or 1+ times per night
☐	☐	Uterine polyps
☐	☐	Other: _____

SURGERY

YES	NO	
☐	☐	Appendix (Appendectomy)
☐	☐	Brain surgery
☐	☐	Biopsy(s)
☐	☐	Breast(s) - Mastectomy / Implants / Reconstruction
☐	☐	Caesarean(s)
☐	☐	Ear operations
☐	☐	Facial / Cosmetic reconstruction
☐	☐	Gallbladder
☐	☐	Nasal polyps
☐	☐	Ovary(s) removal
☐	☐	Prostate removal (Prostectomy)
☐	☐	Testis (Removal / Torsion)
☐	☐	Tonsils removal (Tonsillectomy)
☐	☐	Uterus removal (Hysterectomy)
☐	☐	Vasectomy
☐	☐	Reproductive surgery
☐	☐	Other: _____

HEART / VASCULAR

YES	NO	
☐	☐	Blood pressure (High)
☐	☐	Blood pressure (Low)
☐	☐	High cholesterol
☐	☐	Leg pain while walking
☐	☐	Pain or Discomfort in chest
☐	☐	Painful varicose veins
☐	☐	Palpitations (irregular heartbeat)
☐	☐	Positive stress test
☐	☐	Swelling of feet
☐	☐	Other: _____

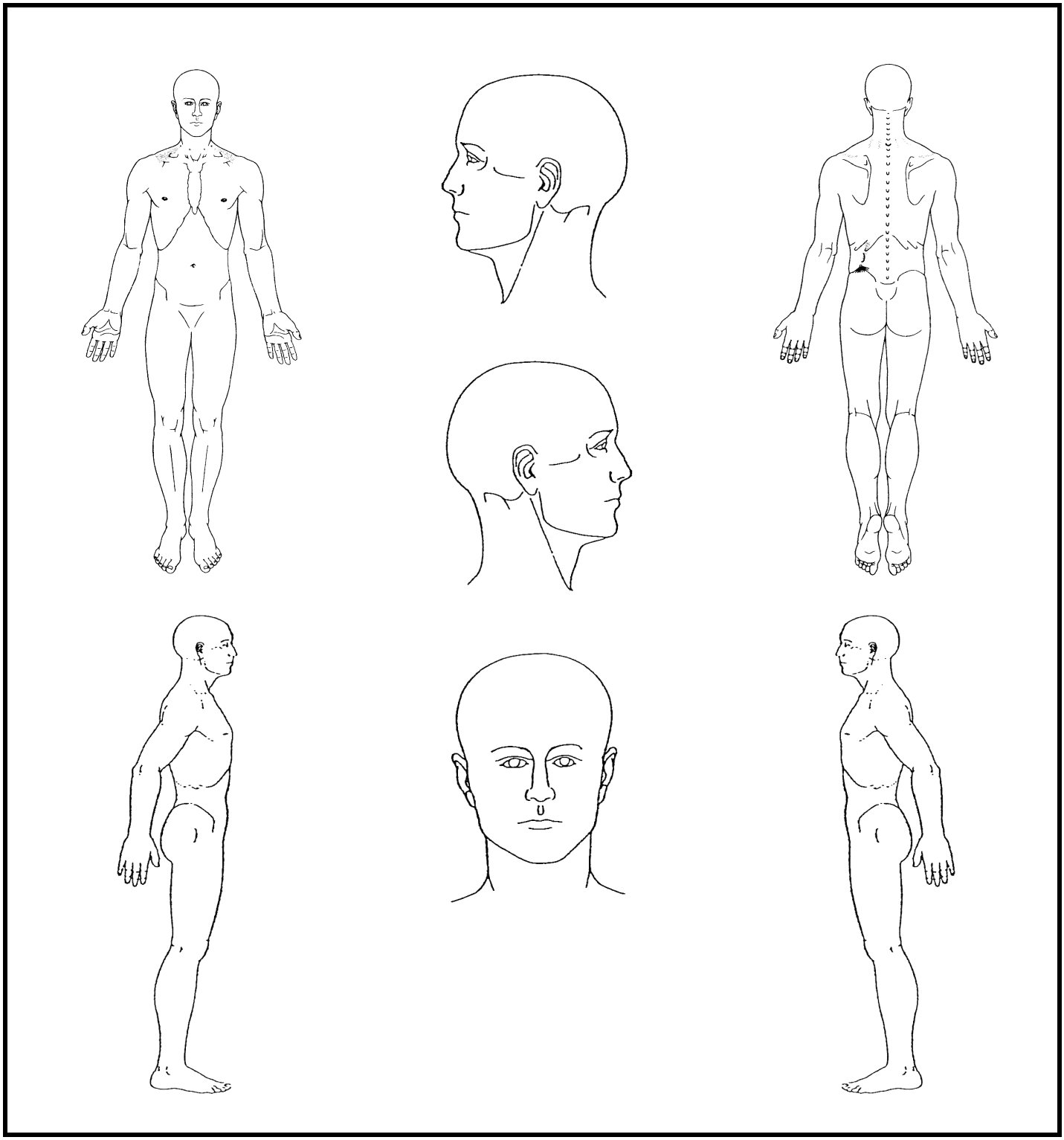
MISCELLANEOUS

YES	NO	
☐	☐	Bacterial infection(s)
☐	☐	Balance issues
☐	☐	Bleeding / bruising easily
☐	☐	Chronic fatigue
☐	☐	Dandruff
☐	☐	Difficulty sleeping
☐	☐	Disturbed sleep patterns
☐	☐	Elevated liver enzyme test
☐	☐	Enlarged glands
☐	☐	Fluid retention
☐	☐	Foot / Nail infection
☐	☐	Glandular fever
☐	☐	Human Immunodeficiency Virus
☐	☐	Insomnia
☐	☐	Loss of feeling in fingers
☐	☐	Loss of feeling in toes
☐	☐	Low blood sugar
☐	☐	Night sweats
☐	☐	Rashes
☐	☐	Ross River Fever
☐	☐	Shuddering in sleep
☐	☐	Sleep apnea
☐	☐	Snoring
☐	☐	Sweating (excessive)
☐	☐	Tinea / Athletes foot
☐	☐	Unexplained lumps
☐	☐	Viral infection(s)
☐	☐	Weight gain (undesired)
☐	☐	Weight loss (undesired)
☐	☐	Other: _____

Notes:

REVIEW OF CONDITIONS (CONTINUED)

Please indicate where you have pain / discomfort in your body:



Notes:

Are you currently on or have recently been on any diet(s) / meal or weight loss plan(s)? ☐ Yes ☐ No

- ☐ Celiac
- ☐ Dairy Free
- ☐ Fasting (intermittent / other)
- ☐ FODMAP / Fructose Free
- ☐ Gluten intolerant
- ☐ High Protein
- ☐ Jenny Craig, Weight Watchers, Lite n' Easy, etc.
- ☐ Low / No Carb
- ☐ Low Fat
- ☐ No special diet
- ☐ Paleo
- ☐ Pescatarian (i.e. a vegetarian who also eats fish)
- ☐ Vegan
- ☐ Vegetarian
- ☐ Wheat Free
- ☐ Other: _____

** Please complete your Food & Health Diary **

WHAT DO YOU WANT?

Please list all of your concerns about your health, eating habits, fitness, and/or body.

Out of all of the above concerns, which ones feel most important / urgent?

1. _____
2. _____
3. _____

Why?

WHAT DO YOU EXPECT?

What do you expect from me as your coach?

What are you prepared to do to work towards your goals?

WHAT DO YOU WANT TO CHANGE?

Have you tried anything in the past to change your health, your eating, your habits, and/or your body? ☐ Yes ☐ No

If so, what?

Which of those things worked well for you? *(Even if you might not be doing it right now.)*

How do you normally cope with your stress?

HOW READY, WILLING, AND ABLE ARE YOU TO CHANGE?

Right now on a scale of 1-10:

How READY are you to change your behaviours and habits?

NOT AT ALL	1	2	3	4	5	6	7	8	9	10	COMPLETELY

How WILLING are you to change your behaviours and habits?

NOT AT ALL	1	2	3	4	5	6	7	8	9	10	COMPLETELY

How ABLE are you to change your behaviours and habits?

NOT AT ALL	1	2	3	4	5	6	7	8	9	10	COMPLETELY

HEALTH APPRAISAL QUESTIONNAIRE – COMPREHENSIVE PATIENT FORM

NAME: _____ DATE: _____

Your answers to this health appraisal questionnaire will assist your practitioner in gaining information about your current symptoms and health concerns. Please answer all questions, in each section.

Circle the number which best describes the frequency or severity of your symptoms over the previous **month**, or answer the **yes** or **no** questions by circling the appropriate letter.

You may note that some questions are repeated throughout the questionnaire. We would appreciate it if you can answer **all** questions, as this will ensure the most accurate interpretation of your results. You may however leave a question blank if you are unsure of the answer.

SECTION 1: GASTROINTESTINAL

Section 1.1 Stomach: Hypoacidity

	Never	Occasionally	Moderately / Often	Frequently / Daily
1. Indigestion	0	1	2	3
2. Excessive belching, burping	0	1	2	3
3. Bloating or fullness commencing during or shortly after a meal	0	1	2	3
4. Sensation of food sitting in stomach for a prolonged period after a meal	0	1	2	3
5. Bad breath	0	1	2	3
6. Loss of appetite, or nausea	0	1	2	3
7. History of anaemia	N			Y (3)

TOTAL: _____

Section 1.2 Stomach: Hyperacidity

1. Stomach pain, burning or aching, 1-4 hours after eating	0	1	2	3
2. Feeling hungry just an hour or two after eating	0	1	2	3
3. Indigestion or heartburn from spicy or fatty food, citrus, alcohol, or caffeine	0	1	2	3
4. Stomach discomfort or pain in response to strong emotions, thoughts, or smell of food	0	1	2	3
5. Heartburn aggravated by lying down or bending forward	0	1	2	3
6. Antacids, carbonated beverages, milk, cream or food relieve the above symptoms	0	1	2	3
7. Constipation	0	1	2	3
8. Difficulty or pain when swallowing	**0**	**2**	**4**	**6**
9. Black tarry stools	**0**	**4**	**8**	**10**
10. Vomiting blood or vomitus has appearance of coffee-grounds	**0**	**4**	**8**	**10**

TOTAL: _____

Section 1.3 Small Intestine/Pancreas

	Never	Occasionally	Moderately / Often	Frequently / Daily
1. Indigestion, bloating and fullness for several hours after eating	0	1	2	3
2. Abdominal cramps or aches	0	1	2	3
3. Nausea and/or vomiting	0	1	2	3
4. Excessive passage of gas	0	1	2	3
5. Diarrhoea (loose, watery or frequent bowel movements)	0	1	2	3
6. Constipation (requiring straining, or a hard, dry or small stool)	0	1	2	3
7. Alternating constipation and diarrhoea	0	1	2	3
8. Undigested food in stools	0	1	2	3
9. Stools greasy, smelly or stick to toilet bowl	0	1	2	3
10. Black tarry stools	**0**	**4**	**8**	**10**
11. Certain foods worsen abdominal symptoms	N			Y (3)
12. Dry flaky skin and dry brittle hair	N			Y (3)
13. Difficulty gaining weight	N			Y (3)

TOTAL: _____

Section 1.4 Colon

1. Lower abdominal pain, cramping and/or spasms	0	1	2	3
2. Lower abdominal pain relieved by passing gas or stool	0	1	2	3
3. Excessive gas and bloating	0	1	2	3
4. Certain foods or stress aggravate lower abdominal pain	0	1	2	3
5. Diarrhoea (loose, watery or frequent bowel movements)	0	1	2	3
6. Constipation (requiring straining, or a hard, dry or small stool)	0	1	2	3
7. Alternating diarrhoea and constipation	0	1	2	3
8. Sensation of incomplete emptying of bowel	**0**	**2**	**4**	**6**
9. Extremely narrow stools	**0**	**2**	**4**	**10**
10. Mucus or pus in stool	**0**	**2**	**4**	**6**
11. Red blood with bowel movement	**0**	**2**	**8**	**10**
12. Rectal pain or cramps	0	1	2	3
13. Anal itching	0	1	2	3

TOTAL: _____

Section 1.5 Liver/Gall Bladder/Pancreas

		Never	Occasionally	Moderately / Often	Frequently / Daily
1.	Upper abdominal pain, or pain under ribs	0	1	2	3
2.	Bloating or feeling of fullness after eating	0	1	2	3
3.	Excessive belching or gas	0	1	2	3
4.	Fatty foods cause indigestion or nausea	0	1	2	3
5.	Loss of appetite	0	1	2	3
6.	Nausea and/or vomiting	0	1	2	3
7.	Unexplained itchy skin	0	1	2	3
8.	**Yellowish discolouration of skin or eyes, or dark coloured urine**	**N**			**Y (8)**
9.	**Pale clay-coloured stools**	**0**	**2**	**4**	**8**
10.	Fatigue, malaise or weakness	0	1	2	3
11.	Fluid retention, oedema	0	1	2	3
12.	Easy bruising, or bleeding (e.g. of gums)	0	1	2	3
13.	Loss or thinning of body hair	N			Y (3)
14.	Red skin, particularly on palms	N			Y (3)
15.	Dry, flaky skin, or dry hair	N			Y (3)

TOTAL:_____

SECTION 2: ENDOCRINE

Section 2.1 Symptoms of underactive thyroid

		Never	Occasionally	Moderately / Often	Frequently / Daily
1.	Fatigue, sluggishness	0	1	2	3
2.	Feeling cold, or intolerance to cold	0	1	2	3
3.	**Swelling or tightness in front of neck**	**N**			**Y (8)**
4.	Constipation (requiring straining, or a hard, dry or small stool)	0	1	2	3
5.	Dry skin and hair	N			Y (3)
6.	Puffy face, hands or feet	0	1	2	3
7.	Gaining of weight, or decreased appetite	N			Y (3)
8.	Low mood	0	1	2	3
9.	Difficulty concentrating, poor memory	0	1	2	3
10.	Low libido	0	1	2	3
11.	Infertility	N			Y (3)
12.	Heavier or more frequent menstrual periods	N			Y (3)

TOTAL:_____

Section 2.2 Symptoms of overactive thyroid

		Never	Occasionally	Moderately / Often	Frequently / Daily
1.	Fatigue, notable weakness in limbs	0	1	2	3
2.	Feeling hot, or intolerance to heat, sweaty	0	1	2	3
3.	**Swelling or tightness in front of neck**	**N**			**Y (8)**
4.	Diarrhoea (loose, watery or frequent bowel movements)	0	1	2	3
5.	Weight loss, possibly with increased appetite	N			Y (3)
6.	Palpitations	0	1	2	3
7.	Nervousness, irritability, restlessness	0	1	2	3
8.	Tremor	0	1	2	3
9.	Insomnia	0	1	2	3
10.	Visual disturbance, problems with eyes, or development of staring gaze	0	2	4	6
11.	Poor libido	0	1	2	3
12.	Light, infrequent or absent menstrual periods	N			Y (3)

TOTAL:_____

Section 2.3 Stress, fatigue and adrenals

1.	Feeling stressed, nervous, or tense, or unable to relax	0	1	2	3
2.	Feeling irritable or oversensitive	0	1	2	3
3.	Feeling overwhelmed, unable to cope	0	1	2	3
4.	Low mood, mood swings	0	1	2	3
5.	Difficulty concentrating or thinking clearly, memory problems	0	1	2	3
6.	Need coffee, tea, tobacco, sugar or chocolate as pick me ups	0	1	2	3
7.	Fatigued, tire easily	0	1	2	3
8.	Find it hard to get up and going in the morning	0	1	2	3
9.	Difficulty staying awake during day	0	1	2	3
10.	Insomnia	0	1	2	3
11.	Palpitations or chest pain	0	1	2	3
12.	Nausea, dizziness	0	1	2	3
13.	Change in appetite	0	1	2	3

TOTAL:_____

SECTION 3: IMMUNE

Section 3.1 Low immunity

		Never	Occasionally	Moderately / Often	Frequently / Daily
1.	Frequent colds or 'flu	N			Y (3)
2.	Frequent infections in other locations (e.g. bladder, skin)	0			3
3.	Diarrhoea	0	1	2	3
4.	Ears continuously drain	0	1	2	3
5.	Nasal congestion or discharge	0	1	2	3
6.	Sore throat	0	1	2	3
7.	Cough with mucus	0	1	2	3
8.	Cold sores	0	1	2	3
9.	Inflamed or bleeding gums, or swollen, red lips or tongue	0	1	2	3
10.	Wounds heal slowly	N			Y (3)
11.	Excessive loss of hair	N			Y (3)
12.	**Neck, armpit or groin swelling**	**0**	**1**	**2**	**6**

TOTAL:_____

Section 3.2 Allergy

1.	Migraine or non-migraine headache	0	1	2	3
2.	Sensitivity to light (skin or eyes)	0	1	2	3
3.	Dark circles under eyes	0	1	2	3
4.	Swollen eyes, lips, face, or other body parts	0	1	2	3
5.	Localised or general itching – eyes, ears, throat, nose, skin	0	1	2	3
6.	Rashes or eczema	0	1	2	3
7.	Clear watery discharge from nose or eyes	0	1	2	3
8.	Sneezing, coughing or wheezing	0	1	2	3
9.	Irritability, fatigue	0	1	2	3
10.	Certain foods worsen symptoms, or cause palpitations	N			Y (3)

TOTAL:_____

SECTION 4: CARDIOVASCULAR

Section 4.1 Healthy red blood cell maintenance

1.	Excessive fatigue	0	1	2	3
2.	Prolonged recovery after exercise	0	1	2	3
3.	Low exercise tolerance, shortness of breath with exertion	0	1	2	3
4.	Dizziness, spots before eyes, or ringing in ears	0	1	2	3
5.	Difficulty concentrating, poor memory	0	1	2	3
6.	**Yellowing of eyes or skin**	**N**			**Y (6)**
7.	Pale eyelids, lips, gums, nails	0	1	2	3
8.	Red sore tongue	0	1	2	3
9.	Sores in corner of mouth	0	1	2	3
10.	Easy bruising or bleeding	0	1	2	3

TOTAL:_____

Section 4.2 Healthy blood pressure maintenance

		Never	Occasionally	Moderately / Often	Frequently / Daily
1.	Headaches	0	1	2	3
2.	Nosebleeds	0	1	2	3
3.	Redness in face	0	1	2	3
4.	Ringing in ears or blurred vision	0	1	2	3
5.	History of high blood pressure	N			Y (6)

TOTAL:_____

Section 4.3 Heart

1.	Palpitations	0	1	2	3
2.	Dizziness	0	1	2	3
3.	**Pain or heaviness in central chest**	**0**	**4**	**8**	**10**
4.	**Heartburn, pain or heavy crushing sensation that moves to neck, jaw, left shoulder or arm**	**0**	**4**	**8**	**10**
5.	**Pallor or sweating with chest discomfort or with unusual indigestion**	**0**	**2**	**4**	**6**
6.	Fatigue easily, poor exercise tolerance	0	1	2	3
7.	Shortness of breath with exertion	0	1	2	3
8.	**Shortness of breath lying flat in bed, or sudden shortness of breath in the middle of the night**	**0**	**4**	**8**	**10**
9.	Wheezing or dry cough	0	1	2	3
10.	Veins on neck are prominent	0	1	2	3
11.	Swelling in feet, ankles or legs	0	1	2	3
12.	History of high blood cholesterol	N			Y (6)

TOTAL:_____

Section 4.4 Circulatory system

		Never	Occasionally	Moderately / Often	Frequently / Daily
1.	Poor circulation in extremities: coldness, or numbness, tingling or pricking sensations in hands or feet, discolouration in fingers or toes	0	1	2	3
2.	Ulcers on feet or legs	N			Y (6)
3.	Muscle pain in calves or thighs with walking	0	1	2	3
4.	Difficulty concentrating, poor memory	0	1	2	3
5.	**Faints, or falls with unknown cause**	**0**	**4**	**8**	**10**
6.	**Brief periods of difficulty speaking, swallowing, or understanding speech or written word**	**0**	**4**	**8**	**10**
7.	**Brief periods of loss of whole or part of vision, double vision, impaired coordination, or areas of numbness**	**0**	**4**	**8**	**10**

TOTAL:_____

SECTION 5: GLUCOSE TOLERANCE

Section 5.1 Symptoms of hypoglycaemia

When you miss a meal, do you feel ...				
1. Fatigue and weakness, or feeling shaky	0	1	2	3
2. Mild headache	0	1	2	3
3. Sweating or palpitations	0	1	2	3
4. Feeling light-headed or faint	0	1	2	3
5. Difficulty concentrating, poor memory, confusion	0	1	2	3
6. Agitation, irritability	0	1	2	3

TOTAL:_____

Section 5.2 Symptoms of hyperglycaemia

1.	Excessive, frequent urination	0	1	2	3
2.	Increased thirst and appetite	0	1	2	3
3.	Blurred vision, failing eyesight	0	1	2	3
4.	Fatigue, drowsiness	0	1	2	3
5.	Profuse sweating	0	1	2	3
6.	Dizziness when standing from sitting position	0	1	2	3
7.	Unintentional weight loss, or excessive weight gain	0	1	2	3
8.	Recurrent or persistent infections (e.g. bladder, skin)	0	1	2	3
9.	Ulcers or sores on legs or feet	N			Y (3)
10.	Slow wound healing	N			Y (3)
11.	Diagnosis of diabetes	N			Y (6)

TOTAL:_____

SECTION 6: GENITOURINARY SYSTEM AND REPRODUCTIVE HORMONES

Section 6.1 Kidney/Bladder

		Never	Occasionally	Moderately / Often	Frequently / Daily
1.	**Fluid retention throughout body**	**0**	**2**	**4**	**8**
2.	Lower back pain	0	1	2	3
3.	Excessive urination	0	1	2	3
4.	Excessive urination during night	0	1	2	3
5.	Burning with urination	0	1	2	3
6.	Frequent urination	0	1	2	3
7.	Urgency of urination	0	1	2	3
8.	Bloody, cloudy or darkened urine, or strong-smelling urine	0	1	2	3
9.	Incontinence	0	1	2	3
10.	**Infrequent urination**	**0**	**2**	**4**	**6**
11.	**Grey cast to skin**	**0**	**2**	**4**	**8**
12.	Severe one-sided lower back or groin pain associated with restlessness	0	1	2	3
13.	History of kidney stones	N			Y (6)

TOTAL:_____

Section 6.2 Prostate/Male hormone balance
(Men only to answer this section)

1.	Difficulty starting urine flow, or poor flow of urine	0	1	2	3
2.	Sense of bladder fullness, incomplete emptying, or needing to strain with small amounts of urine passed	0	1	2	3
3.	Dripping after urination	0	1	2	3
4.	**Ejaculation causes pain**	**0**	**2**	**4**	**8**
5.	**Blood in semen**	**0**	**2**	**4**	**8**
6.	Low libido	0	1	2	3
7.	Difficulty attaining or maintaining an erection	0	1	2	3
8.	Premature ejaculation	0	1	2	3
9.	Low energy level or stamina	0	1	2	3
10.	Infertility, low sperm count or poor motility	N			Y (3)
11.	**Inflammation of penis, or unusual discharge from penis**	**N**			**Y (6)**
12.	Genital or groin rash, irritation, itchiness or infection	0	1	2	3
13.	**Painful testicle(s)**	**0**	**2**	**4**	**8**
14.	**Testicles uneven in size, texture or hardness**	**N**			**Y (8)**
15.	Both testicles appear smaller	N			Y (3)
16.	Loss or thinning of body or facial hair, or slow hair growth	N			Y (3)
17.	Development of breasts or nipple tenderness	N			Y (3)

TOTAL:_____

Section 6.3 Symptoms of PMS (Women only to answer this section)

Symptoms experienced in the 3 to 14 days prior to menstruation, in the last 3 months

		Never	Occasionally	Moderately / Often	Frequently / Daily
1.	Insomnia	0	1	2	3
2.	Abdominal bloating	0	1	2	3
3.	Breast tenderness, swelling or lumps	0	1	2	3
4.	Feeling depressed, teary, or sensitive	0	1	2	3
5.	Feeling anxious, irritable, or easily angered	0	1	2	3
6.	Diarrhoea or constipation	0	1	2	3
7.	Headaches or migraines	0	1	2	3
8.	Food cravings or binge eating	0	1	2	3
9.	Back pain	0	1	2	3
10.	Fluid retention or weight gain	0	1	2	3
11.	Clumsiness	0	1	2	3
12.	**Feeling aggressive, or feeling suicidal**	**0**	**4**	**8**	**10**

TOTAL:_____

Section 6.4 Menstrual irregularities (Women only to answer this section)

Symptoms experienced in the past 3 months

1.	Irregular intervals between periods	N			Y (3)
2.	Long period cycles, greater than 32 days	N			Y (3)
3.	Short period cycles, less than 24 days	N			Y (3)
4.	**Vaginal bleeding between periods**	**N**			**Y(10)**
5.	Painful periods – lower abdomen or back	0	1	2	3
6.	**Pain with periods is worsening**	**N**			**Y (6)**
7.	Painful intercourse during menstruation	0	1	2	3
8.	Pelvic and/or rectal pressure around menstruation	0	1	2	3
9.	Constipation or diarrhoea with menstruation	0	1	2	3
10.	Nausea and/or vomiting with menstruation	0	1	2	3
11.	Light blood flow	N			Y (3)
12.	Heavy blood flow, or flooding	N			Y (3)
13.	Passage of large or profuse blood clots	N			Y (3)
14.	Prolonged duration of bleeding	N			Y (3)
15.	Number of days _____				
16.	**Absence of menstrual flow for more than 5 months**	**N**			**Y (6)**

TOTAL:_____

Section 6.5 Symptoms of menopause (Women only to answer this section)

		Never	Occasionally	Moderately / Often	Frequently / Daily
1.	Irregular menstrual cycle and/or changes in menstrual flow (heavier or lighter)	N			Y (3)
2.	Dry skin, hair or vagina	0	1	2	3
3.	Low libido	0	1	2	3
4.	Mood swings, irritability, depression, nervousness, anxiety	0	1	2	3
5.	Hot flushes	0	1	2	3
6.	Night sweats	0	1	2	3
7.	Headaches or dizziness	0	1	2	3
8.	Painful intercourse	0	1	2	3
9.	Insomnia	0	1	2	3
10.	Difficulty concentrating, poor memory, or confusion	0	1	2	3
11.	Thinning of armpit and pubic hair, or increased hair growth on upper lip	N			Y (3)
12.	Breasts reducing in size and starting to sag	N			Y (3)

TOTAL:_____

Section 6.6 Other female sexual and hormonal problems (Women only to answer this section)

1.	Vaginal dryness or pain	0	1	2	3
2.	Painful intercourse	0	1	2	3
3.	Milk production (not nursing), or engorged breasts	0	1	2	3
4.	Low libido	0	1	2	3
5.	Excessive libido	0	1	2	3
6.	Acne and/or oily skin	0	1	2	3
7.	Excess facial hair	N			Y (3)
8.	Breasts shrinking	N			Y (3)
9.	Thinning body hair	N			Y (3)
10.	Infertility	N			Y (3)
11.	Miscarriage	N			Y (3)
12.	Vaginal discharge: excessive, smelly, or coloured	0	1	2	3
13.	Burning or itching of external genitalia	0	1	2	3
14.	Vaginal bleeding after intercourse, or between periods	0	1	2	3
15.	Lower abdominal or back pain	0	1	2	3
16.	**Breast lumps, or a change in breast size or shape**	**N**			**Y (8)**
17.	**Nipple discharge, or change in appearance of nipple**	**0**	**2**	**6**	**8**
18.	**Swelling under armpit**	**N**			**Y (6)**

TOTAL:_____

SECTION 7: MUSCULOSKELETAL

Section 7.1 Bone

		Never	Occasionally	Moderately / Often	Frequently / Daily
1.	Generalised bone tenderness or achiness	0	1	2	3
2.	Localised bone pain	0	1	2	3
3.	**Bone deformity or swelling**	**N**			**Y (8)**
4.	Shins hurt during or after exercise	0	1	2	3
5.	Low back or hip pain	0	1	2	3
6.	Walking difficulties, or a limp	0	1	2	3
7.	**Hearing loss, headaches, ringing in ears**	**N**			**Y (8)**
8.	Diagnosis of osteoporosis	N			Y (8)
9.	Abnormal spinal curvature	N			Y (6)
10.	Recent loss of height	N			Y (8)
11.	Bowed legs	N			Y (3)
12.	Stooped posture or hump at base of neck	N			Y (3)
13.	**Unexplained bone fracture**	**N**			**Y (8)**

TOTAL:_____

Section 7.2 Muscle

1.	Muscle aches and pains	0	1	2	3
2.	Muscle stiffness, tension	0	1	2	3
3.	Specific body points are tender to touch	0	1	2	3
4.	Headaches	0	1	2	3
5.	Fatigue	0	1	2	3
6.	Difficulty sleeping	0	1	2	3
7.	Muscle cramps or spasms	0	1	2	3
8.	Muscles twitch or tremble	0	1	2	3
9.	Restless legs	0	1	2	3
10.	Upper or lower back pain	0	1	2	3
11.	**Muscle weakness**	**0**	**2**	**4**	**8**
12.	**Muscle loss and wasting**	**N**			**Y (8)**

TOTAL:_____

Section 7.3 Connective tissue

1.	Tender, red, swollen, and stiff joints	0	1	2	3
2.	Dry mouth, dry, painful eyes	0	1	2	3
3.	Creaking (noisy) joints	0	1	2	3
4.	Limp	0	1	2	3
5.	**Shooting, aching, tingling pain down back of leg**	**0**	**2**	**4**	**6**
6.	Joint pain involves more than one joint	0	1	2	3
7.	Limited range of motion	0	1	2	3
8.	Difficulty standing up from seated position	0	1	2	3
9.	Impaired mobility or function	0	1	2	3
10.	Difficulty chewing or opening mouth	0	1	2	3

Section 7.3 Connective tissue (Continued)

		Never	Occasionally	Moderately / Often	Frequently / Daily
11.	**Numbness, prickling, tingling sensation in neck, shoulders or arms**	**0**	**2**	**4**	**6**
12.	Injure, strain, sprain easily	N			Y (3)
13.	Red, painless skin lumps on elbows, knees, toes	N			Y (3)
14.	Knobbly joints	N			Y (3)
15.	Muscle wasting	N			Y (3)

TOTAL:_____

SECTION 8: BRAIN AND NERVOUS SYSTEM

Section 8.1 Neurological

1.	Headache	0	1	2	3
2.	**Light-headedness, fainting**	**0**	**2**	**4**	**6**
3.	Ringing or buzzing in ears	0	1	2	3
4.	Trembling hands	0	1	2	3
5.	**Weakness**	**0**	**2**	**4**	**6**
6.	**Numbness, pins and needles, or tingling in limbs**	**0**	**2**	**4**	**6**
7.	**Unsteady on feet**	**0**	**2**	**6**	**8**
8.	Easily fatigued	0	1	2	3
9.	**Poor hand coordination**	**0**	**2**	**6**	**8**
10.	**Convulsions, seizures or funny turns**	**0**	**4**	**8**	**10**
11.	Difficulty concentrating, confused, poor memory	0	1	2	3
12.	Clumsy	0	1	2	3
13.	**Drooping eyelid(s)**	**0**	**2**	**4**	**6**
14.	**Impaired hearing, eyesight, sense of touch, smell or taste**	**0**	**4**	**8**	**10**
15.	**Slow or slurred speech**	**0**	**4**	**8**	**10**
16.	**Incontinence**	**0**	**2**	**4**	**6**

TOTAL:_____

Section 8.2 Stress history

In past 2 years have you experienced...					
1.	Divorce	N			Y (4)
2.	Separation from partner	N			Y (4)
3.	Marriage	N			Y (3)
4.	Death of close family member or friend	N			Y (4)
5.	Loss of work, retirement or starting a new job	N			Y (3)
6.	Bankruptcy, or a major change in finances	N			Y (3)
7.	Moving house	N			Y (2)
8.	Major personal injury or illness	N			Y (3)
9.	Violations of the law	N			Y (2)

TOTAL:_____

Section 8.3 Symptoms of insomnia

Do you...	Never	Occasionally	Moderately / Often	Frequently / Daily
1. Have an overactive mind, or worry excessively	0	1	2	3
2. Live or work in a stressful environment	0	1	2	3
3. Suffer from constant pain or discomfort	0	1	2	3
4. Eat chocolate or drink caffeine in the evenings	0	1	2	3
5. Have difficulty falling asleep or staying asleep	0	1	2	3
6. Eat after 8pm	0	1	2	3

TOTAL:_____

Section 8.4 Normal, healthy learning and concentration

Do you...				
1. Find if difficult to keep still or are fidgety	0	1	2	3
2. Have a short attention span	0	1	2	3
3. Find it difficult to relax	0	1	2	3
4. Experience mental confusion or sluggishness	0	1	2	3
5. Have or had learning difficulties	N			Y (3)
6. Have food allergies	N			Y (2)

TOTAL:_____

SECTION 9: RESPIRATORY SYSTEM

1. Shortness of breath, increased effort to breathe	0	1	2	3
2. Wheezing	0	1	2	3
3. Shallow breathing	0	1	2	3
4. Cough, dry or moist	0	1	2	3
5. Thick yellow, greenish or brown sputum	0	1	2	3
6. Blood in sputum	**0**	**2**	**4**	**6**
7. Frothy sputum	**0**	**2**	**4**	**6**
8. Noisy rattling sounds when breathing	0	1	2	3
9. Pain in chest	0	1	2	3
10. Bad breath or sputum smells offensive	0	1	2	3
11. Loud snoring	0	1	2	3
12. Colds always "go to the chest"	N			Y (3)
13. Bluish nails or lips	**0**	**2**	**4**	**10**

TOTAL:_____

SECTION 10: HAIR, SKIN AND NAILS

	None	Mild	Moderate	Severe
1. Acne	0	1	2	3
2. Psoriasis	0	1	2	3
3. Eczema/dermatitis	0	1	2	3
4. Warts	0	1	2	3
5. Tinea	0	1	2	3
6. Dandruff	0	1	2	3

SECTION 10: HAIR, SKIN AND NAILS (Continued)

	Never	Occasionally	Moderately / Often	Frequently / Daily
7. Rashes	0	1	2	3
8. Areas of increased pigmentation	0	1	2	3
9. Areas of decreased pigmentation	0	1	2	3
10. Unusual or changing moles	**N**			**Y (4)**
11. Areas of unexplained redness	0	1	2	3
12. Undiagnosed skin lumps/bumps	**N**			**Y (4)**
13. Discoloured nails	0	1	2	3
14. Pitted nails	0	1	2	3
15. Weak/brittle nails	0	1	2	3
16. Thickened nails	0	1	2	3

TOTAL:_____

SECTION 11: DETOXIFICATION (capacity)

As far as you are aware, do you have a sensitivity or allergy to ...

	None	Mild	Moderate	Severe
1. The preservatives sodium benzoate or potassium benzoate	0	1	2	3
2. Tyramine (red wine, cheese, bananas, chocolate)	0	1	2	3
3. Caffeine	0	1	2	3
4. Chemicals such as fragrances, exhaust fumes, cigarette smoke or other strong odours	0	1	2	3
5. Even small amounts of alcohol	0	1	2	3
6. Do you have a history of exposure to chemicals such as herbicides, insecticides, pesticides or organic solvents?	N			Y (3)
7. Alcohol (number of drinks per week)	0	1-7 (1)	8-14 (2)	15+ (3)
8. Coffee or other caffeinated drinks (number per day)	0	1-2 (1)	3-4 (2)	5+ (3)
9. Smoking (number per day)?	0	1-8	9-19	20+
10. Type_____		(3)	(3)	(6)
11. If not currently smoking, have you quit smoking in the last year?	N			Y (2)
12. Recreational drugs?	N			Y (3)
13. Type_____				
14. What is your blood type? _____				

TOTAL:_____

SECTION 12: GENERAL HEALTH HISTORY

Section 12.1 Patient health history

		Never	Occasionally	Moderately / Often	Frequently / Daily
1.	Frequency of exercise (days per week)	6-7	3-5	1-2	0
		(0)	(1)	(2)	(3)
2.	Vegetarian or vegan	N			Y (2)
3.	Age >50 years	N			Y (3)
4.	Planning to have a baby in the next 3-6 months	N			Y (3)
5.	Pregnant or breastfeeding	N			Y (3)

TOTAL:_____

Section 12.2 Weight management

1.	Do you diet often?	N			Y (3)
2.	Are you unhappy with your weight?	N			Y (3)

TOTAL:_____

Section 12.3 High risk symptoms

1.	**Unexplained weight loss**	**N**			**Y (6)**
2.	**Night sweats**	**0**	**2**	**4**	**6**
3.	**Fevers**	**0**	**2**	**4**	**6**
4.	**Lumps, e.g. breast, armpit, skin**	**N**			**Y (6)**
5.	**Reduced appetite**	**0**	**2**	**4**	**6**
6.	**Severe fatigue**	**0**	**2**	**4**	**6**

TOTAL:_____

Section 12.4

	Which of the following types of medications have you taken in the last 6 months?	Never	Occasionally	Moderately / Often	Frequently / Daily
1.	Asthma medications/inhalers	N			Y
2.	Anti-diabetics/insulin	N			Y
3.	Steroids e.g. cortisone	N			Y
4.	Anti-inflammatories/aspirin	N			Y
5.	Paracetamol	N			Y
6.	High blood pressure	N			Y
7.	Heart	N			Y
8.	Thyroid	N			Y
9.	Antihistamines				
10.	Antiulcer medications, antacids	N			Y
11.	Antibiotics/antifungals	N			Y
12.	Antidepressants	N			Y
13.	Antipsychotics	N			Y
14.	Relaxants/sleeping tablets	N			Y
15.	Hormones/oral contraceptives	N			Y
16.	Chemotherapy	N			Y
17.	Any other medications?	N			Y
18.	Type_____				

List the nutritional or herbal supplements you are currently taking _____

_____

_____

_____

List any major health problems in past, surgery, etc_____

_____

_____

_____

List your major health concerns at present_____

_____

_____

_____

Family History

Do you have a family history of diabetes, cardiovascular disease, cancer, or any other major illness?_____

_____

_____

_____

_____

Thank you, for your taking the time to complete this questionnaire.

Food & Health Diary

Day 1: (Day & Date): _____

Time of day								
Water (volume)								
Fluids (type & volume)								
Food/Snacks								
Medications/ Supplements (e.g. type, dosage)								
Energy (0 = Low, 10 = High)								
Exercise/Physical activity (type & intensity)								
Emotions/Feelings (e.g. contented, angry, sad)								
Aches/Pains (type, location & intensity)								
Bowel movements (e.g. frequency, movement type, etc)								
Sleep (hours, quality, etc)								
Stress level (0 = Low, 10 = High)								
General Notes/ Other								

Signature: _____ Date: _____

Food & Health Diary

Day 2: (Day & Date): _____

Time of day								
Water (volume)								
Fluids (type & volume)								
Food/Snacks								
Medications/ Supplements (e.g. type, dosage)								
Energy (0 = Low, 10 = High)								
Exercise/Physical activity (type & intensity)								
Emotions/Feelings (e.g. contented, angry, sad)								
Aches/Pains (type, location & intensity)								
Bowel movements (e.g. frequency, movement type, etc)								
Sleep (hours, quality, etc)								
Stress level (0 = Low, 10 = High)								
General Notes/ Other								

Signature: _____ Date: _____

Food & Health Diary

Day 3: (Day & Date): _____

Time of day								
Water (volume)								
Fluids (type & volume)								
Food/Snacks								
Medications/ Supplements (e.g. type, dosage)								
Energy (0 = Low, 10 = High)								
Exercise/Physical activity (type & intensity)								
Emotions/Feelings (e.g. contented, angry, sad)								
Aches/Pains (type, location & intensity)								
Bowel movements (e.g. frequency, movement type, etc)								
Sleep (hours, quality, etc)								
Stress level (0 = Low, 10 = High)								
General Notes/ Other								

Signature: _____ Date: _____

Medication & Supplement Register

*Please list **ALL** medications (prescription and non-prescription) and supplements (vitamin, mineral, herbal, oil or other) that you are currently taking or have recently taken (i.e. within the last 6 months - please state if/when ceased). This list should include medications as part of a current or previous medical treatment regime, such as chemotherapy, pain management, vaccinations, cardiovascular conditions (i.e. cholesterol, high blood pressure), laxatives, antibiotics, stress, depression, ADD/ADHD, medical trial(s), etc.*

	Name/Type (drug, supplement, vaccination, other)	Manufacturer	Concentration (mg, mcg)	Dosage/Frequency (times per day)	Reason for use and when commenced and/or ceased
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

Medication & Supplement Register

	Name/Type (drug, supplement, vaccination, other)	Manufacturer	Concentration (mg, mcg)	Dosage/Frequency (times per day)	Reason for use and when commenced and/or ceased
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

Declaration

I, _____ hereby certify, to my full knowledge and belief, that this is a true and accurate record of all medications (prescription and non-prescription), vaccinations, supplements (natural and/or synthetic), herbs, vitamins, oils, etc that I am currently taking or have previously taken.

Signature: _____

Name (please print): _____ Date: _____

Dr Kristian Ronacher

'The Good Food Doctor' - *Let food be your medicine*

Consultation Agreement

I _____ (the 'client') agree to the following conditions for the upcoming consultation and working relationship with Wholistic Health, Nutrition and Wellbeing consultant and wholefood nutritionist Dr Kristian Ronacher, PhD (the 'nutritionist'):

- The information I the client have provided and/or will provide via questionnaires, phone, email, in-person, or by any other means of communication is accurate to the best of my knowledge
- The recommendations I the client will receive from Dr Kristian Ronacher are not a substitute for medical advice from a qualified and registered medical practitioner/doctor
- The advice I the client will receive from Dr Kristian Ronacher is personal and applies to me only. This same advice may be ineffective or even harmful when applied to other people with different a background
- I the client must communicate to Dr Kristian Ronacher any changes in my medical prescriptions or treatments for the duration of my nutrition guidance/program/plan
- I must inform Dr Kristian Ronacher promptly if any of my new changes in diet or lifestyle start to cause me adverse effects or reactions
- I understand that the advice, recommendations, education, coaching, guidance and support that I shall receive will not be enough to achieve my health, nutrition, wellbeing, and/or lifestyle goals unless I follow them diligently and commit to them fully
- I understand any changes in my diet and lifestyle may produce effects in my body, energy, health, and condition that are gradual in nature – not instantaneous
- I understand that, although Dr Kristian Ronacher will endeavor to help me achieve my health, nutrition, wellbeing, and lifestyle goals to the extent possible, the possibility exists I may not fully attain my goals due to factors outside the control of Dr Kristian Ronacher

I have read and understood the terms above and I agree to them.

Signature: _____ Date: _____

Print Name: _____