Date:

New Client Registration Form

First Name: **Surname**:

Date of Birth:

Address:

Suburb: **State:** **Postcode**:

Parent/Guardian (if under 18):

Contact No:

Email address:

Medicare Number: Ref on Card: Expiry Date:

Veterans Affair Card Number:

Private Health Insurance Card Number: Expiry Date:

Occupation:

How did you find out about FAID?:

Reason for seeing a FAID Dietitian:

Relevant Medical History: *e.g. eczema, asthma*

Relevant blood and/or allergy test results:

Do you have or have you ever had (if yes, please provide details)**:**

☐ **An Eating Disorder?**

☐ **Anxiety / Depression?**

Are you following or have you ever tried a special diet? (if yes please provide details).
E.g. 2019 low FODMAP diet – some improvement in gut symptoms

☐ Allergen avoidance
☐ Low FODMAP
☐ Vegetarian / Vegan
☐ Gluten / Wheat Free
☐ Dairy / Lactose free
☐ Low food chemical
☐ Other (please specify)

Please list any foods that you suspect trigger symptoms: *e.g. apples – bloating*

Are you currently avoiding or limiting any foods in your diet? If yes, please specify.

Please list any medications or supplements you currently take:

Is there anything else you would like to add?

Privacy Protection:
By completing this form you are consenting to the collection of your health information. Please email this form along with any other relevant documents/test results to hello@faid.com.au

Accredited Practising Dietitian