JAMES H. LYONS, NUTRITIONIST

THE GENDER CENTRE INC
SERVICES FOR THE TRANSGENDER AND GENDER DIVERSE COMMUNITY

NEW PATIENT INTAKE FORM

FULL NAME:

DATE OF BIRTH: AGE:

GENDER (OPTIONAL): PRONOUNS:

ADDRESS:

PHONE NUMBER:

EMAIL:

OCCUPATION (OPTIONAL):

Do you identify as any of the following? (please circle)

ABORIGINAL: YES / NO
TORRES STRAIT ISLANDER: YES / NO

EMERGENCY CONTACT

NAME: PHONE:

What are your most important health concerns?

Diagnosed medical conditions:

What would you like to get out of your consultation?

Known Allergies/Intolerances:

Suspected Allergies/Intolerances:

Current Medications & Supplements (including dosage and reason for taking):

Informed Consent & Privacy

I hereby request and consent to the performance of nutritional medicine treatments and other procedures within the scope of the practice of nutritional medicine.

To the best of my ability all the information given here is a true and accurate representation of my /my child's health.

Your privacy is protected under the Privacy Act (1988) in accordance with Australian Privacy Principles. Your information will not be shared with any third parties except in the event of an emergency or legal request.

I give my permission for my health history to be kept on file for the purpose of nutritional care, planning & prescribing.

SIGNED: DATE:

If the client is under 18 years of age, the parent/guardian is required to sign the consent form.

JAMES H. LYONS
NUTRITIONAL MEDICINE