Anita Rossiter

BSc, BAppSci(MedRad), GradDip(HumanNutrition)

42 Kevin Drive, Hidden Valley, Qld, 4703

Phone: 0411 816 521

Email: anita@eatand3veg.com.au

Thank you for expressing interest in a consultation. This letter gives relevant information for your consideration. Please return the attached information and we will organise a health history consultation. Confidentiality is always maintained.

About this practice

Anita graduated from post-graduate human nutrition studies at Deakin University in 2014 following a 15 year career in diagnostic medical imaging (Nuclear Medicine and Positron Emission Tomography) in Melbourne, London and Tasmania. While studying nutrition, she also trained as a health coach which is where she quickly discovered that there is much more to optimal health than just food. Following completion of her studies, she became a qualified practitioner with MINDD Foundation which is focused on child health especially the mind-gut health connection. In practice however the interest quickly diversified to include the whole family!

She has a very keen interest in highly sensitive people both children and adults and loves to work with them holistically to look beyond some of the issues (mental health, mood disorders, gut disturbances, food sensitivities) that may be preventing them reaching their brilliance.

Services provided:

Consultations:

- Nutritional assessment and advice for existing health issues
- Addressing specific dietary queries
- Integrate and liase with GP's to make sustainable changes to diet and lifestyle

Coaching:

- One on one health and nutrition coaching. Beneficial if troubled by any of the following:

    - Weight gain/inability to lose weight
    - Fatigue
    - Hormonal disturbances
    - Autoimmunity
    - Candida
    - Mood disorders
    - Anxiety, depression
    - Bloating
    - Skin rashes
    - Food sensitivities
    - Gut issues

- Helping holistically to help you reach your brilliance

HEALTH HISTORY

Name: ____ **Date:** ____________

DOB: ________________________________

Address: ____

____

Email: ____

Phone No: ____

What are your main reasons for attending this appointment?

____

____

____

Medical Background:

Blood Group (if known): ____

Allergies:____

Please list any operations you have had:

____

____

Do you have/ have you had any significant illnesses?

Diabetes	Y / N	Liver Disease	Y / N
Thyroid Disease	Y / N	Blood Disorder	Y / N
Hypertension	Y / N	Arthritis	Y / N
Heart Disease	Y / N	Cancer	Y / N
Depression	Y / N	Chronic Fatigue	Y / N
Severe Gastro	Y / N	Chronic Ear Infections	Y / N
Asthma	Y / N	Eczema	Y / N

How is / was the health of your parents? ___________________________________

____

How were you born? Natural Birth Caesarean

How were you fed? Breastfed (How long?________) Formula Fed

Did you require antibiotics in your first year of life? Y / N

How was your health as a child?

____

____

____

____

Review Of Symptoms & History

	Do you suffer from……	Yes / No / Further Info
Digestive	Heartburn or reflux	
	Bloating after meals	
	Constipation	
	Burping or passing wind	
	Diarrhoea or loose stools	
	Nausea	
	Stomach ulcers or pain	
	Gall Bladder Problems	
Lung	Pneumonia or Bronchitis	
	Wheeze	
Immune system	Boils	
	Cold Sores	
	Conjunctivitis	
	Ear Infection	
	Genital Infection	
	Sinus Infection	
	Mouth Ulcers	
	Sore throat	
	Thrush	
	Tonsilitis	
	Urinary Infection	
Skin, hair, nails	Acne or pimples	
	Brittle nails	
	Dry eyes	
	Dry mouth	
	Dry skin	
	Early greying of hair	
	Eczema or dermatitis	
	Hair loss	
	Psoriasis	

	Rashes	
	Sore or cracked lips	
	Tinea or ringworn	
	Stretch marks	
	White spots on nails	
	Warts	
	White spots on skin	
Women’s hormonal	Breast lumps or cysts	
	Breast tenderness	
	Endometriosis	
	Fibroids	
	Ovarian cysts	
	PMS/PMT	
	Been on HRT	
	Been on oral contraceptive	
Sleep	Disrupted sleep	
	Insomnia	
	Snoring	
	Waking up exhausted	
Nervous/muscular	Anxiety or agitation	
	Irritability	
	Migraine	
	Headache	
	Poor night vision	
	Gout	
	Dizziness or vertigo	
	Facial twitching	
	Restless legs	
	Fits or seizures	
	Blurred vision	
	Leg, foot or hand cramps	
	Depression	
	Memory loss	
	Chronic pain	
	Muscle pain	
	Mood swings	
	Muscle weakness / heaviness	
	Pins and needles / numbness	
	Poor concentration	
	Poor balance	
	Tinnitus (ringing in the ears)	
	Tremor of the hands	

How much water do you drink? ____

What is your salt intake? ____

Do you drink tea, coffee or caffeinated drinks? How often?

____

Do you / have you ever smoked? ____

How much alcohol do you drink? ____

Are you taking any prescription medications?

____

____

____

Are you taking any vitamins/supplements? Please list……

____

____

____

What role does sport and exercise play in your life?

____

____

How is your sleep? ___________ How many hours? _________ Do you wake? Y/N

Do you follow a particular way of eating? (Vegetarian, gluten-free etc?)

____

What foods did you eat often **as a child**?

Breakfast: ____

Lunch: ____

Snacks: ____

Drinks: ____

What is your food like **lately?**

Breakfast: ____

Lunch: ____

Snacks: ____

Drinks: ____

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? Y / N

Do you cook? Y / N

What percentage of your food is home cooked? ___________________________

Where do you get the rest? ____

____

Do you crave sugar, coffee, cigarettes or have any major addictions?

____

____

The most important thing I should change to improve my health is:

____

____

____

Thank you for completing this questionnaire.

Warm Wishes,

Anita Rossiter